

We are complimented that you have selected us to provide dental care for you and your family.

Patient Information

Date _____ Patient's Name _____
Last First Middle
(If patient is a full time student, fill in the school name) _____
Address _____
Street City State Zip
Home Phone _____ Cell Phone _____ Social Security # _____
Birthdate _____ Age _____ If patient is minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____
Name of nearest relative not living with you _____
Complete Address _____ Phone _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Cell Phone _____ Relationship To Patient _____
Social Security # _____ Birthdate _____ Work Phone _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship To Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Phone _____
Is the policy connected with your union? Yes _____ No _____ Name of Union _____ Local No. _____
Do you have dual coverage? Yes _____ No _____ If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Phone _____
Insured's Employer _____ Phone _____

Preference For Payment

- CASH OR CHECK ON DAY OF TREATMENT
- BANK AMERICARD / MASTERCHARGE
- DENTAL INSURANCE + CO-PAYMENT (CASH, CHECK OR CHARGE CARD)
- MEDI-CAL

Notes:

Please complete back page

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, please explain _____					
3. Are you taking any medication(s) including non-prescription medicine? ie: Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, what medication(s) are you taking? _____					
4. Have you ever taken Phen-Fen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have or have you had any of the following:					
	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

9. Are you ALLERGIC to or have you had any reactions to the following:					
Local Anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>			
Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>			
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>			
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>			
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>			
Iodine	<input type="checkbox"/>	<input type="checkbox"/>			
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			
Any Metals (eg. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>			
Eggs	<input type="checkbox"/>	<input type="checkbox"/>			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>			

10. Women Only:					
Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>			

Patient Dental History

Name of Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>			
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>			
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Have you ever experienced any of the following problems in your jaw?					
Clicking	<input type="checkbox"/>	<input type="checkbox"/>			
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
10. Do you bite your lips or your cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>			
11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>			
13. Have you ever had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, date of placement _____					
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the

actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient (or parent, if minor) X _____

Doctor's Comments _____ _____ _____ _____ _____ Signature _____ Date _____

**PLEASE LIST ALL MEDICATION(S) YOU ARE CURRENTLY TAKING
ALONG WITH THE PHYSICANS NAME, TELEPHONE AND FAX
NUMBER.**

**PLEASE BRING THIS FORM AND THE PATIENT INFORMATION
SHEET TO YOUR APPOINTMENT. THANK YOU**

MEDICATION (S) PHYSICIAN PHONE/FAX NUMBER

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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