



12120 Alta Carmel Ct.
 Suite 410C
 San Diego, CA 92128
 TEL: (858) 385-9188
 FAX: (858) 385-9328

GETTING TO KNOW YOU AS OUR PATIENT:

Date:

Patient Name:		Social Security Number - -	Home Phone ()
Home Address		City, state, Zip	Cell Phone
Email Address		Work Phone	
Marital Status: Single Divorced Married Separated	<input type="radio"/> Female <input type="radio"/> Male	Birthdate / /	Drivers License and State
Primary Insurance Company _____		Group _____	Subscriber _____
Secondary Insurance Company _____		Group _____	Subscriber _____
Responsible Party			
Name		Social Security Number	Home Phone
Home Address		City, State, ZIP	Birth date
Marital Status: Single Married Divorced Separated		Relationship to Patient	Drivers License and State
Responsible Person's Employer		Occupation	Work Phone
Business Address		City	State, ZIP

Spouse's Name	Social Security Number	Birthdate
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City	State, ZIP

How did you hear about our Office?
(check only one)

Who selected this office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office? _____

Referred by a friend Yellow Pages Relative Insurance Plan Welcome Wagon
 Other _____ TV/ Radio Ad Newspaper AD Direct mailing Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT
<ul style="list-style-type: none"> I will answer all the health questions to the best of my knowledge. _____ <div style="text-align: right;"><i>(Initial)</i></div>

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

***Signature** **Date** **Relationship to Patient**

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes please, tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.

Y N My gums bleed while brushing or flossing.

Y N I like my smile.

Y N I prefer tooth- colored fillings.

Y N I avoid brushing part of my mouth due to pain.

What are your dental priorities? _____

(e.g.: appearance, dental health, financial considerations, etc.)

If female please answer the following:

Y N Are you taking Birth Control Pills?

Y N Are you pregnant? If yes, # of weeks

Y N Are you nursing?

Please answer the following:

Y N Do you smoke or use tobacco? Height: _____

For Office Use Only

BP: _____

Heart Rate: _____

Weight: _____

Y N	<u>Conditions</u>	Y N	<u>Conditions</u>	Y N	<u>Allergies</u>
Y N	Abnormal Bleeding	Y N	Hepatitis A	Y N	Aspirin
Y N	Alcohol/ Drug Abuse	Y N	Hepatitis B	Y N	Codeine
Y N	Anemia	Y N	High Blood Pressure	Y N	Dental Anesthetics
Y N	Angina Pectoris	Y N	Implant/ Replacements	Y N	Erythromycin
Y N	Arthritis	Y N	Kidney Problems	Y N	Jewelry
Y N	Artificial Bones	Y N	Liver Disease	Y N	Latex
Y N	Artificial Heart Valve	Y N	Low Blood Pressure	Y N	Metals
Y N	Asthma	Y N	Major Surgery	Y N	Penicillin
Y N	Blood Transfusion	Y N	Mitral Valve Prolapsed	Y N	Tetracycline
Y N	Cancer- Chemotherapy	Y N	Pace Maker	Other _____	
Y N	Colitis	Y N	Pneumocystitis	Physician's Name: _____	
Y N	Congenital Heart Defect	Y N	Psychiatric Problems	Phone: _____	
Y N	Cosmetic Surgery	Y N	Radiation Therapy	Fax: _____	
Y N	Diabetes	Y N	Rheumatic Fever	Please list all medications you are taking:	
Y N	Difficulty Breathing	Y N	Seizures	Medicine: _____	
Y N	Emphysema	Y N	Shingles	Condition: _____	
Y N	Epilepsy	Y N	Sickle Cell Disease	Medicine: _____	
Y N	Fainting Spells	Y N	Sinus Problems	Condition: _____	
Y N	Frequent Headaches	Y N	Stroke	Medicine: _____	
Y N	Glaucoma	Y N	Taken Fen- Phen	Condition: _____	
Y N	HIV+ AIDS	Y N	Thyroid Problems	Medicine: _____	
Y N	Heart Attack	Y N	Tuberculosis	Condition: _____	
Y N	Heart Murmur	Y N	Ulcers	Medicine: _____	
Y N	Heart Surgery	Y N	Venereal Disease	Condition: _____	
Y N	Hemophilia	Y N	Yellow Jaundice		

In the event of emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/ dental health reviewed by:

X _____ / _____ / _____
Doctor's Signature *Date*

Periodic medical/ dental health reviewed by:

X _____ / _____ / _____
X _____ / _____ / _____

X _____ / _____ / _____
Patient's Signature *Date*

X _____ / _____ / _____
If patient is a minor: Parent/ Guardian's Signature