Patient Name:_____ Age:_____ Birth Date:_____

Address:_____ Phone #:_____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized, had surgery, or had a serious illness in the last three years?
   If YES, explain:_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam? _____ Name of Physician _____ Phone # _____
5. Yes No Have you had problems with prior dental treatment? Explain:_____
6. Yes No Are you in pain now? Explain:_____

II. DO YOU HAVE OR HAVE YOU HAD:

7. Yes No High blood pressure?
8. Yes No Irregular heart rate or pacemaker?
9. Yes No Heart attack?
10. Yes No Chest pain (angina)?
11. Yes No Heart murmurs?
12. Yes No Heart defects?
13. Yes No Rheumatic fever?
14. Yes No Stroke?
15. Yes No Heart valve problem or replacement?
16. Yes No Coronary artery blockage/treatment (bypass/stent)?
17. Yes No Low blood pressure?
18. Yes No Past use of Fen-Phen?
19. Yes No Asthma?
20. Yes No Emphysema or respiratory problems?
21. Yes No Chronic sinus problems?
22. Yes No Tuberculosis or persistent cough?
23. Yes No Diabetes?
24. Yes No Thyroid problems?
25. Yes No Abnormal bleeding, bruise easily?
26. Yes No Hemophilia?
27. Yes No Anemia/blood disease?
28. Yes No Cancer?
29. Yes No Radiation therapy/chemotherapy?
30. Yes No Bisphosphonate use?
31. Yes No Organ transplant?
32. Yes No Blood transfusion?
33. Yes No Joint replacement (artificial knee/hip)?
34. Yes No Arthritis?
35. Yes No Osteoporosis?
36. Yes No Fainting spells/dizziness?
37. Yes No Seizures?
38. Yes No Numbness or muscle weakness?
39. Yes No Multiple sclerosis?
40. Yes No Developmental delay?
41. Yes No Autism?
42. Yes No Down syndrome?
43. Yes No Dementia/Alzheimer's disease?
44. Yes No Anxiety?
45. Yes No Depression?
46. Yes No Bipolar disease, schizophrenia?
47. Yes No Mental health treatment?
48. Yes No Hepatitis?
49. Yes No Liver disease?
50. Yes No Kidney disease/dialysis?
51. Yes No Stomach problems, ulcers?
52. Yes No Gastroesophageal reflux disease?
53. Yes No Sexually transmitted disease?
54. Yes No HIV/AIDS?
55. Yes No Speech therapy?
56. Yes No Oral Habits(grinding, thumb sucking, tongue thrust)?

III. DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING?

57. Yes No Penicillin or other antibiotics?
58. Yes No Sulfa drugs?
59. Yes No Dental anesthetic?
60. Yes No Aspirin?
61. Yes No Codeine/narcotics?
62. Yes No Latex products?
63. Yes No Metals/nickels/jewelery?
64. Yes No Foods_____
65. Yes No Other_____

IV. ARE YOU TAKING?

66. Yes No Alcohol?
67. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
68. Yes No Tobacco in any form?
69. Yes No Recreational drugs?

List all medications you are currently taking:_____

_____

V. WOMEN ONLY:

70. Yes No Are you or could you be pregnant or nursing?
71. Yes No Taking birth control?

VI. ALL PATIENTS

72. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If yes, explain: _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature: _____ Date: _____

(If minor, signature of parent or guardian)

Dentist's Signature: _____ Date: _____

Patient Information

Patient Name / Nombre _____ Age / Edad_____ Sex / Sexo ☐M ☐F

Birthdate / Fecha de Nacimiento _____ Weight / Peso _____ Phone / Teléfono_____

Address / Dirección _____ Apt. # _____

City /Ciudad _____ State / Estado _____ Zip Code / Zona _____

Driver's License # / Numero de Licencia _____ Social Security # / Número de Seguro Social_____

Marital Status / Estado Civil: ☐ Minor / Menor de Edad ☐ Single /Soltero(a) ☐ Married/Casado(a) ☐ Divorced/Divorciado(a) ☐ Separated/Separado(a)

Legal Guardian or Spouse / Guardian Legal o Esposo(a)_____ Phone / Teléfono_____

Occupation / Occupación _____ Employed by / Empleado(a) por _____

Business Phone / Teléfono del Empleador _____ E-mail_____

Emergency Contact Name / Contacto de Emergencia _____ Phone / Teléfono_____

Relation to Patient / Relación con el Paciente _____

Dental Information

Reason for dental visit today (pain, checkup, etc.) / Razón de la visita de hoy (dolor, chequeo, etc.):
_____

Previous Dentist / Dentista Previo_____ Date of Last Dental Exam / Fecha del Ultimo Examen Dental_____

Reason for changing dentists / Razón de cambio de dentistas: _____

Have you ever had braces? / ¿Ha tenido frenos en el pasado? ☐ Yes / Si ☐ No

How Did You Hear About Our Office? / ¿Como supo de nuestra oficina?
☐ Employer / Empleador ☐ Relative / Pariente ☐ Friend / Amigo ☐ Internet ☐ Insurance Plan / Aseguranza ☐ Passed by / Pasar por la oficina

If you were referred, whom may we thank for referring you? ¿Quien lo refirió a nuestra oficina?
_____

Insurance Information

Name of Insurance Carrier/ Compañía de Seguros_____

Name of Subscriber / Nombre del Asegurado_____

Subscriber's Birthdate / Fecha de nacimiento del Suscriptor_____

Subscriber's Social Security # / Número del Seguro Social del Suscriptor_____
Relationship to Insured / Relacion del Paciente con el Asegurado ☐ Self / Yo mismo ☐ Spouse / Esposo(a) ☐ Child / Hijo(a)

Name of Employer / Empleador_____

Do you have a secondary insurance? / ¿Tiene seguro secondario? ☐ Yes / Si ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

If you would like to review a copy of the document in our office or have one copied for you to take home, please ask the receptionist. You may also obtain a copy from the dental board of California at http://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf

I acknowledge that I have received a copy of the Dental Materials Fact Sheet.

_____

Patient Name

X_____

Signature of Patient, Parent, or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

We are required by applicable federal and state law to maintain the privacy of your health information and to provide you notice of our privacy practices. Such notice has been delivered to you today that include your rights to access, disclosure accounting, restriction and amendments as well as uses and disclosures of your health information that this office may provide for treatment, payment, and healthcare operations, under your authorization and in limited other circumstances. We have notified you that it is important for you to carefully review the information contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient Name

X_____

Signature of Patient, Parent, or Legal Guardian Date