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DATE: _____

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____–_____–_____ ☐ MALE ☐ FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED PHONE #: MOBILE _____ OFFICE _____ HOME _____

_____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____ RELATION: _____

EMERGENCY PHONE #: _____

PHARMACY NAME: _____ PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY DENTAL INSURANCE

IS SUBSCRIBER THE SAME AS PATIENT? YES ☐ NO ☐

SUBSCRIBER INFORMATION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____

INSURANCE COMPANY

NAME: _____

SUBSCRIBER ID: _____

GROUP #: _____

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SPOUSE ☐ CHILD ☐ OTHER: _____

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

IS SUBSCRIBER THE SAME AS PATIENT? YES ☐ NO ☐

SUBSCRIBER INFORMATION

FIRST NAME: _____

LAST NAME: _____

DATE OF BIRTH: _____

INSURANCE COMPANY

NAME: _____

SUBSCRIBER ID: _____

GROUP #: _____

PATIENT RELATIONSHIP TO SUBSCRIBER

☐ SPOUSE ☐ CHILD ☐ OTHER: _____

RESPONSIBLE PERSON INFORMATION (Parent/Spouse)

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____–_____–_____ ☐ MALE ☐ FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____/_____/_____

REASON FOR VISIT: ☐ BROKEN TOOTH ☐ CHECK-UP ☐ COSMETIC ☐ DENTURES ☐ TOOTH PAIN

☐ OTHER: _____

ARE YOU UNDER THE CARE OF A PRIMARY CARE PHYSICIAN? ☐ YES ☐ NO
DATE OF LAST PHYSICAL: _____

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY STEROID/CORTISONE THERAPY IN THE LAST 2 YEARS? ☐ YES ☐ NO

ARE YOU TAKING OR HAVE YOU TAKEN ORAL BISPHOSPHONATES (E.G., FOSAMAX, BONIVA) OR IV BISPHOSPHONATES, (E.G., ZOMETA, AREDIA)? ☐ YES ☐ NO HOW LONG? _____

DO YOU REQUIRE ANTIBIOTICS PRIOR TO DENTAL PROCEDURES? ☐ YES ☐ NO

ARE YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

☐ NONE ☐ AMOXICILLIN ☐ ASPIRIN ☐ CODEINE ☐ EPINEPHRINE ☐ LATEX ☐ METALS ☐ NOVOCAIN ☐ SULFA

☐ PENICILLIN ☐ SULFA ☐ TETRACYCLINE ☐ OTHER: _____

DO YOU SNORE? _____ CPAP? _____

_____

LIST ANY MEDICATIONS YOU ARE TAKING INCLUDING NON-PRESCRIPTION DRUGS AND HERBALS/VITAMINS:

_____

_____

_____

_____

TO BETTER PROPERLY HELP YOU, CHECK ANY CONDITIONS THAT APPLY TO YOU

☐ NONE

☐ ALCOHOLISM

☐ ALLERGIES OR HIVES

☐ ANEMIA

☐ ARTHRITIS

☐ ARTIFICIAL JOINT/PINS
TYPE: _____
AGE: _____

☐ ASPIRIN THERAPY

☐ ASTHMA

☐ BLOOD THINNER

☐ BLOOD TRANSFUSION

☐ BREATHING PROBLEMS

☐ CANCER
TYPE: _____

☐ CHEMOTHERAPY

☐ COUMADIN THERAPY

☐ DEMENTIA

☐ DIABETES
TYPE: _____

☐ DIALYSIS

☐ DRUG ADDICTION

☐ EPILEPSY

☐ EXCESSIVE BLEEDING

☐ FAINTING/DIZZINESS

☐ HEARING IMPAIRMENT

☐ HEART MURMUR

☐ HEART SURGERY
DATE: _____

☐ HEART TROUBLE
TYPE: _____

☐ HEPATITIS
TYPE: _____

☐ HIGH BLOOD PRESSURE

☐ HIV

☐ KIDNEY DISEASE

☐ LIVER DISEASE

☐ LOW BLOOD PRESSURE

☐ LUNG DISEASE/COPD

☐ LUPUS

☐ MITRAL VALVE PROLAPSE

☐ MOBILITY IMPAIRMENT

☐ NON-DENTAL IMPLANTS
TYPE: _____

☐ ORGAN TRANSPLANTS
TYPE: _____

☐ PACE MAKER

☐ PSYCHIATRIC CARE

☐ RADIATION THERAPY

☐ RADIOSURGERY

☐ RHEUMATIC FEVER

☐ SEIZURES

☐ STD

☐ SINUS PROBLEMS

☐ STOMACH PROBLEMS

☐ STROKE

☐ THYROID DISEASE

☐ TUBERCULOSIS (TB)

☐ ULCERS

☐ VISUAL IMPAIRMENT TYPE: _____ _____

☐ OTHER DISEASE/ILLNESS _____

DATE OF LAST DENTAL VISIT:

☐ I DON'T KNOW EXACT DATE ☐ LAST 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS
☐ GREATER THAN 4 YEARS ☐ NEVER

DATE OF LAST DENTAL X-RAY:

☐ I DON'T KNOW EXACT DATE ☐ LAST 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS
☐ GREATER THAN 4 YEARS ☐ NEVER

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL (GUM) DISEASE? ☐ YES ☐ NO

HAVE YOU EVER HAD NOVOCAINE OR OTHER LOCAL ANESTHETIC? ☐ YES ☐ NO

HOW HAPPY ARE YOU WITH YOUR SMILE (Rate it 1-10)? _____

ARE YOU CURRENTLY WEARING DENTURES? ☐ YES ☐ NO

AGE OF DENTURES: ☐ LESS THAN 6 MONTHS ☐ 6 MONTHS – 1 YEAR ☐ 1 – 3 YEARS
☐ GREATER THAN 4 YEARS

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU BELOW

☐ PAIN IN JAW (TMJ)	☐ DIFFICULTY CHEWING/SWALLOWING	☐ USE TOBACCO PRODUCTS	☐ MOUTH SORES
☐ BROKEN/LOOSE TEETH	☐ TEETH GRINDING/CLENCHING	☐ SWOLLEN/BLEEDING GUMS	☐ SENSITIVE TEETH

WOMEN:

ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO ESTIMATED DELIVERY DATE: _____

ARE YOU NURSING? ☐ YES ☐ NO
ARE YOU TAKING ANY BIRTH CONTROL PRESCRIPTIONS? ☐ YES ☐ NO

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS AND ACKNOWLEDGE THAT QUESTIONS HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY CONSENT TO THE DENTIST TO PERFORM AN EXAMINATION AND DIAGNOSE MY CONDITION. I ALSO GIVE MY CONSENT FOR ANY PREVENTATIVE OR BASIC RESTORATIVE PROCEDURES WHICH MAY BE NECESSARY. I UNDERSTAND THAT THIS CONSENT WILL REMAIN IN EFFECT UNTIL TREATMENT IS TERMINATED EITHER BY ME OR THE DENTIST.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

You may scan and email back to us at: dougmaxson@comcast.net

Or FAX it to (408) 996-0392 or bring it with you to your next appointment.