3780 EL CAJON BLVD, SUITE 1 * SAN DIEGO, CA 92105

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PATIENT INFORMATION (Confidential)

NAME____M __ F __
FIRST MIDDLE LAST SEX

ADDRESS______________________________CITY___________________________STATE________ZIP___________

EMAIL________________________________ SS#___________________________BIRTHDATE___________ AGE _____

PHONE: CELL___________________________WORK__________________________BEST TIME TO CALL___________

IF WE HAVE ANY CHANGES TO OUR SCHEDULE MAY WE CONTACT YOU? YES ___ NO ___

CHECK APPROPRIATE: MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED ___

IF COLLEGE STUDENT: FULL TIME ___ PART TIME ___ SCHOOL NAME______________________CITY______________STATE _____

PATIENT'S OR PARENT'S EMPLOYER ____

BUSINESS ADDRESS_______________________CITY___________________________STATE________ZIP___________

SPOUSE OR PARENT'S NAME____

EMPLOYER____WORK PHONE ______________________

EMERGENCY CONTACT ____ PHONE ___________________________

RESPONSIBLE PARTY (Confidential)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____

RELATIONSHIP TO PATIENT___________________ADDRESS ____

PHONE______________________SS#______________________DRIVERS LISCENSE # _____________________________

BIRTHDATE___________________EMPLOYER_____________________________WORK PHONE ______________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES ___ NO ___

X ____DATE_____________________________
SIGNATURE OF PATIENT OR PARENT IF MINOR

MEDICAL HISTORY (Confidential)

	YES	NO
1. ARE YOU IN GOOD HEALTH?	___	___
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	___	___

3. DATE OF YOUR LAST PHYSICAL EXAM: ________________

4. PHYSICIAN'S NAME ________________

ADDRESS ________________

PHONE ________________

	YES	NO
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	___	___
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	___	___

PLEASE EXPLAIN ________________

	YES	NO
7. ARE YOU TAKING ANY MEDICINES INCLUDING NONPRESCRIPTION MEDICINES?	___	___

IF YES, WHAT ARE YOU TAKING? ________________

	YES	NO
8. BRUISE EASILY OR ABNORMAL BLEEDING?	___	___
9. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	___	___
10. HAVE YOU HAD A RECENT WEIGHT LOSS?	___	___
11. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?	___	___
12. HAVE YOU EVER HAD BIPHOSPHONATE DRUGS FOR CANCER OR OSTEOPOROSIS?	___	___
13. DO YOU USE TOBACCO?	___	___
14. DO YOU OR HAVE YOU USED CONTROLLED DRUGS?	___	___
15. ARE YOU WEARING CONTACT LENSES?	___	___
16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT?	___	___
17. WOMEN:		
Are you pregnant?	___	___
Are you nursing?	___	___
Are you Taking Birth Control Pills?	___	___
18. ARE YOU ALLERGIC TO OR HAVE YOU HAD SERIOUS REACTIONS (other than stomach upset) TO:		
Local Anesthetics like Novocain	___	___
Penicillin or Other Antibiotics	___	___
Sulfa Drugs	___	___
Barbiturates, Sedatives or Sleeping Pills	___	___
Aspirin or Similar NSAIA's	___	___
Iodine or Shellfish	___	___
Any Metals or Latex	___	___

OTHER (please list) ________________

____

19. DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:

	YES	NO
Rheumatic Heart Disease or Rheumatic Fever	___	___
Scarlet Fever	___	___
Heart Defect/Murmur, Mitral Valve Prolapse	___	___
Heart Surgery, Trouble, Attack, or Angina	___	___
Chest Pain, Shortness of Breath, Pacemaker	___	___
High / Low Blood Pressure	___	___
Sinus trouble	___	___
Lung or Breathing Problems Asthma or Hay Fever	___	___
Hives or Skin Rash	___	___
Fainting or Dizzy Spells	___	___
Diabetes	___	___
AIDS or HIV Infection	___	___
Thyroid Problems	___	___
Allergies	___	___
Arthritis, rheumatism, fibromyalgia	___	___
Joint Replacement or Any Implant	___	___
Stomach Ulcer, Reflux, IBS, Crohn's	___	___
Kidney Trouble	___	___
Tuberculosis, Persistent or Bloody Cough	___	___
Chemotherapy for Cancer or Leukemia	___	___
Sexually Transmitted Disease	___	___
Epilepsy or Seizures, M.S.	___	___
Anemia or Blood Disorders	___	___
Glaucoma	___	___
Nervousness or Phobias	___	___
Tumors or Cancer	___	___
Back Problems	___	___
Chemical Dependency, Addictions	___	___
Cortisone Treatment	___	___
Cold Sores / Fever Treatment Hypoglycemia	___	___
Eating Disorders, Bulimia, Anorexia	___	___
Chronic Pain Condition	___	___
Head or Neck Trauma, Whiplash	___	___
Hyperchondriosis	___	___

Mental Health Care: Diagnosis ________________

Other ________________

DENTAL HISTORY (Confidential)

Reason for This Visit: ____

Date of Last Dental Visit: ____

What was done? ____

Previous dentist name / location: __________________________________

Current home care: How often do you brush?________ Floss? _________

Circle all that you are concerned about / currently have:

Sensitivity to: Hot *or* Cold *or* Sweets — Tooth Pain / Ache

Cavities	Gum disease	Pain to Bite
Broken Teeth	Broken Fillings	Missing Teeth
Dark Teeth	Ugly Teeth	Crooked Teeth
Bad Breath	Clicking jaw	Fear of Dentist
Loose Teeth	Spacing	Grinding / Clenching
Jaw or Face Pain	Headaches	Want whiter teeth
Want to Save Teeth	Poor dentistry	Want Gentle Dentist
Dream Teeth Fall Out	Recession	Cosmetic Dentistry
Snoring / Apnea	Bleeding Gums	Nothing

I am changing dentists because: (Check any that apply)

- ___ Recently moved into this area from_______________
- ___ Dr / Staff Personality - Communication Problem
- ___ Inadequate Care - Fee Concern - Insurance
- ___ I need a second opinion or better option on dental care.
- ___ To find a dentist team who understands my needs.

I have avoided dental care in the past because:

- ___ Time commitment
- ___ Financial commitment
- ___ No perceived need
- ___ Trust factor
- ___ Fear of ____

Are you interested in exploring (check any that apply):

- ___ Dental wellness (going beyond good health)
- ___ Ways to reduce or eliminate periodontal surgery
- ___ Invisalign invisible orthodontic aligners
- ___ ZOOM office whitening or home whitening
- ___ The best dental home care system (Sonicare ETB)
- ___ A good restaurant in the area
- ___ I.V. Sedation and Sleep Dentistry
- ___ Sedation Dentistry (taking a pill) options
- ___ Smile Makeover -- Smile Analysis & Design
- ___ Why dental infections cause heart & other diseases

If you could change anything about your smile, what would you change? ____

Your occupation and job: ___________________________________

Schools attended: ____

Spouse's name & occupation: ________________________________

Children's names, ages? ____________________________________

Where are you from originally? _______________________________

What's more fun than dental visits? ___________________________

How did you first hear about us? (Check any that apply)

- ___ Family member already comes here
- ___ Referred by a friend -Who?
- ___ Convenient location (Walking by)
- ___ I received your Magazine in the mail
- ___ I got a postcard in the Mail
- ___ I Saw your Internet web site
- ___ I dreamed I should come here
- ___ Social media links: ___ Facebook ___ LinkedIn
- ___ I prayed for help and here I am

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____________________________________ , have received a copy of this office's Notice of Privacy Practices.

x _____________________________________ **Date** ___________

Signature of Patient or Parent if Minor

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 agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models or photos for scientific, teaching or promotional purposes.

x _____________________________________ **Date** ___________

Signature of Patient or Parent if Minor