PASADENA
Family dentistry

Date.....

PLEASE PRINT

PLEASE NOTE:
Cancellations made within 24 hours of your scheduled appointment are subject to a $50 cancellation fee.

Initials.....

PATIENT INFORMATION

NAME..... AGE..... DATE OF BIRTH..... ❑ MALE ❑ FEMALE

ADDRESS..... CITY..... STATE..... ZIP.....

❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED SOCIAL SECURITY NUMBER.....

OCCUPATION..... EMPLOYER.....

EMPLOYER ADDRESS..... EMPLOYER PHONE.....

SPOUSE'S NAME..... DATE OF BIRTH..... SS#.....

SPOUSE'S OCCUPATION..... SPOUSE'S EMPLOYER.....

WHOM MAY WE THANK FOR REFERRING YOU?.....

DENTAL INSURANCE

PERSON RESPONSIBLE FOR THIS ACCOUNT..... RELATIONSHIP TO PATIENT.....

INSURANCE COMPANY..... GROUP #.....

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ❑ YES ❑ NO POLICYHOLDER'S NAME.....

DATE OF BIRTH..... SS#..... RELATIONSHIP TO PATIENT.....

INSURANCE COMPANY..... GROUP #.....

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with..... and assign directly to Pasadena Family Dentistry all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pasadena Family Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE..... RELATIONSHIP..... DATE.....

CONTACT INFORMATION

PHONE Home..... Work..... Cell.....

BEST TIME AND PLACE TO CONTACT YOU.....

EMAIL ADDRESS (used only for appointment confirmation).....

IN CASE OF EMERGENCY, PLEASE CONTACT: (Specify someone who does not live in your household)

NAME..... RELATIONSHIP.....

PHONE Home..... Work..... Cell.....

MEDICAL HISTORY

PATIENT NAME (please print)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

			IF YES, PLEASE EXPLAIN:
Are you under a physician's care now?	☐ YES	☐ NO	
Have you ever been hospitalized or had a major operation?	☐ YES	☐ NO	
Have you ever had a serious head or neck injury?	☐ YES	☐ NO	
Are you taking any medications, pills, or drugs? (List in the space provided below.)	☐ YES	☐ NO	
Do you take, or have you taken, Phen-Fen or Redux?	☐ YES	☐ NO	
Are you on a special diet?	☐ YES	☐ NO	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ YES	☐ NO	

Do you use tobacco? ☐ YES ☐ NO

Do you use any controlled substances? ☐ YES ☐ NO

FOR WOMEN: ☐ Are you pregnant / trying to get pregnant? ☐ Are you nursing? ☐ Are you taking oral contraceptives?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

DO YOU HAVE, OR HAVE YOU EVER HAD:

- ☐ AIDS / HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve*
- ☐ Artificial Joint*
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells / Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack / Failure
- ☐ Heart Murmur*
- ☐ Heart Pace Maker*
- ☐ Heart Trouble / Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse*
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever*
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

☐ High Cholesterol ☐ Osteoporosis

* Condition may require medication prior to dental treatment.

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? ☐ YES ☐ NO

MEDICATIONS

COMMENTS

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Pasadena Family Dentistry of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date

MEDICAL HISTORY

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