Contemporary Family Dentistry

Richard E. Garcia DDS

Patient Information

Today's Date _____

___Dr. ___Mr. ___Mrs. ___Miss ___Ms. Name : _____

Address :_____City : _____State : _____Zip : _____

Home Phone # _____Work Phone #_____ Cellular/Pager #_____

Social Security # _____ Date of Birth _____ Email Address_____

Patient's Employer _____Spouse's Name _____ _____ Social Security #_____

Spouse's Date of Birth _____ Spouse's Employer _____Spouse's Work #_____

Relative to Contact in Case of Emergency _____ Phone #_____

Whom May We Thank for Referring You?_____

Responsible Party

If this information is the same as above you may skip to the next section. Otherwise complete the following information.

Name of Person Responsible for this Account _____ Relationship to Patient_____

Address _____ Employer _____

Home Phone #_____ Work Phone #_____

Insurance Information

Name of Insured _____ Relationship to Patient_____ Date of Birth_____

Social Security # _____ Name of Employer_____

Work Phone #_____ Insurance Company_____

Group #_____ Insurance 800 # _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I also understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that cancellations require 48 hr notice or a charge of $50 dollars will apply per appointment.

X_____

(Signature of Patient or Parent if Minor)

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Patient Medical History

Physician Name _____ Office Phone _____ Date of Last Medical Exam _____

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease	__	__	Epilepsy or Convulsions	__	__	Hepatitis	__	__
High Blood Pressure	__	__	Respiratory Problems	__	__	Steroid Therapy	__	__
Heart Attack	__	__	Asthma	__	__	Thyroid Problems	__	__
Stroke	__	__	Emphysema	__	__	Parkinson's Disease	__	__
Angina	__	__	COPD	__	__	Stomach Troubles or Ulcers	__	__
Mitral Valve Prolapse	__	__	Tuberculosis	__	__	Eating Disorders	__	__
Heart Murmur	__	__	Hay Fever or Allergies	__	__	AIDS or HIV Infection	__	__
Rheumatic Fever	__	__	Cancer	__	__	Drug Abuse or Alcoholism	__	__
Cardiac Pacemaker	__	__	Radiation Therapy	__	__	Cold Sores or Fever Blisters	__	__
Anemia	__	__	Arthritis	__	__	Glaucoma	__	__
Hemophilia	__	__	Joint Replacement or Implant	__	__	Recent Weight Loss	__	__
Leukemia	__	__	Kidney Disease	__	__	Latex Allergy	__	__
Diabetes	__	__	Liver Disease	__	__	Other _____	__	__
Women: Are you pregnant?	__	__	Do you think you might be?	__	__	Are you taking contraceptives?	__	__

	Yes	No		Yes	No
1. Are you under medical treatment now? If so, please explain below.	__	__	4. Do you use tobacco or tobacco products?	__	__
2. Have you ever been hospitalized for any surgical operation or serious illness?	__	__	5. Do you consume alcohol?	__	__
3. Are you taking any medication(s) including non-prescription medicine? If so, please list below.	__	__	6. Are you allergic to or have you had any reaction to any medications or foods? If so, please list below.	__	__
			7. Is there anything else we should know?	__	__

Explanations : _____

_____

_____

Patient Dental History

	Yes	No
1. Do you feel pain from any of your teeth?	__	__
2. Are your teeth sensitive?	__	__
3. Do your gums ever bleed while brushing or flossing?	__	__
4. Do you have any sores or lumps in or near your mouth?	__	__
5. Have you had any head, neck, or jaw injuries?	__	__
6. Have you experienced any of the following problems in your jaw? Please circle: clicking, pain, difficulty in opening or closing, difficulty in chewing	__	__
7. Do you have frequent headaches?	__	__
8. Do you clench or grind your teeth?	__	__
9. Do you bite your lips or cheek frequently?	__	__
10. Have you ever had any difficulty or prolonged bleeding following extractions?	__	__
11. Have you experienced bad breath or a bad taste in your mouth?	__	__
12. Have you had any orthodontic treatment?	__	__
13. Have you ever had trouble with local anesthesia in the dental office?	__	__
14. Would you like to change anything concerning the size, shape, or color of your teeth?	__	__
15. Are you interested in taking steps to prevent future dental disease?	__	__

Doctor's Notes: _____

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