

W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient) _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address (if different from patient) _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____
 Former Dentist _____ Address _____
 Dentist's Email _____ Phone _____
 Date of last dental care _____ Date of last x-rays _____
 Check (☒) yes or no if you have had problems with any of the following:

☐ Y ☐ N Bad breath	☐ Y ☐ N Food collection between teeth	☐ Y ☐ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets
☐ Y ☐ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity when biting
☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Sensitivity to hot	☐ Y ☐ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____
 Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
 Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____
 Date of last visit _____ Have you had any serious illnesses or operations? ☐ Y ☐ N
 If yes, describe _____
 Are you currently under physician care? ☐ Y ☐ N If yes, describe _____
 Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____
 Have you ever taken Fen-Phen/Redux? ☐ Y ☐ N
 Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

Check (☒) yes or no whether you have had any of the following:

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shingles
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes	☐ Y ☐ N Liver disease	☐ Y ☐ N Skin rash
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Material allergies (latex, wool, metal, chemicals)	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	☐ Y ☐ N Nervous problems	☐ Y ☐ N Surgical implant
☐ Y ☐ N Asthma	☐ Y ☐ N Glaucoma	☐ Y ☐ N Pacemaker/Heart surgery	☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Psychiatric care	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tobacco habit
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	Describe _____	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/Abnormal bleeding	☐ Y ☐ N Rheumatic/Scarlet fever	☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Herpes		☐ Y ☐ N Venereal disease
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Hepatitis		
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N High blood pressure		

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

BROOKSIDE DENTAL ASSOCIATES

12 North 5th Street
Redlands, CA 92373-5189

PATIENT NAME: _____

HEALTH HISTORY CONTINUED.....

Have you ever taken, Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? Yes _____ No _____

PATIENT SCREENING FOR AEROSOL TRANSMISSIBLE DISEASES (ATD)

DO YOU HAVE:

A history of Tuberculosis? Yes _____ No _____ If yes, explain: _____

Symptoms of Tuberculosis?

Productive cough (>3 weeks): Yes _____ No _____ If yes, explain: _____

Bloody sputum: Yes _____ No _____ If yes, explain: _____

Night sweats: Yes _____ No _____

Fatigue: Yes _____ No _____

Malaise: Yes _____ No _____

Fever: Yes _____ No _____

Unexplained weight loss: Yes _____ No _____

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

DO YOU HAVE:

How long? Explain:

Fever? Yes _____ No _____

Body aches? Yes _____ No _____

Runny nose? Yes _____ No _____

Sore throat? Yes _____ No _____

Headache? Yes _____ No _____

Nausea? Yes _____ No _____

Vomiting or diarrhea? Yes _____ No _____

Fever & respiratory symptoms? Yes _____ No _____

Severe coughing spasms? Yes _____ No _____

Painful, swollen glands? Yes _____ No _____

Skin rash, blisters? Yes _____ No _____

Stiff neck, mental changes? Yes _____ No _____

In compliance with California OSHA Title 8, Section 5199, dental facilities must pre-screen patients for aerosol transmissible diseases. Dental procedures are not performed on patients suspected or identified as having aerosol transmissible diseases.

Chronic Respiratory Diseases (NOT ATD's, are not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199:

DO YOU HAVE:

Asthma? Yes _____ No _____

Allergies? Yes _____ No _____

Chronic upper airway cough syndrome "postnasal drip"? Yes _____ No _____

Gastroesophageal reflux disease (GERD)? Yes _____ No _____

Chronic obstructive pulmonary disease (COPD)? Yes _____ No _____

Emphysema? Yes _____ No _____

Bronchitis? Yes _____ No _____

Dry cough from ACE inhibitors? Yes _____ No _____

PATIENT'S NAME

HEALTH HISTORY UPDATE

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____

Date _____

Health Changes _____

1. _____

2. _____

3. _____

4. _____

Patient's Signature _____ Staff Initials _____