WELCOME

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 Bleeding gums
❑Y ❑N Clicking or popping jaw
❑Y ❑N Food collection between teeth
❑Y ❑N Grinding or clenching teeth
❑Y ❑N Loose teeth or broken fillings
❑Y ❑N Periodontal treatment
❑Y ❑N Sensitivity to cold
❑Y ❑N Sensitivity to hot
❑Y ❑N Sensitivity to sweets
❑Y ❑N Sensitivity when biting
❑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 Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy
❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Food allergies
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia/ Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis
❑Y ❑N High blood pressure
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease
❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Spina Bifida
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

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

720 Brookside Avenue, Suite 100/101
Redlands, Ca. 92373

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 trasmissible 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__________