

Marina District Dentistry

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Patient Information

Date _____
NAME _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Zip _____
Email _____ Cell Phone _____ Soc. Sec. # _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer _____ Work Phone _____
Business Address _____ City _____ State/Zip _____
Spouse or Parent/Guardian's Name _____ Work Phone _____
Spouse or Parent/Guardian's Employer _____ City _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency (living in same home) _____ Phone _____
Person to Contact in Case of Emergency (not living in same home) _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email (optional) _____ Cell Phone _____
Driver's License # _____ Birthdate _____ SSN _____
Employer _____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Are there other family members? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Co. Address _____ City _____ State/Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No

IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Co. Address _____ City _____ State/Zip _____

Patient's Medical History

Patient's Name _____

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Are you taking any medication, pills, or prescription drugs?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Are you on a special diet?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Do you use tobacco?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____
Do you use controlled substances?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> N/A	_____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?
Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anesthetics ☐ Other (Please specify) _____

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

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

*Condition may require medication. N/A – Not answered by patient

Have you ever had any serious illness not listed above? Yes No N/A If yes, please specify _____

Comments: _____

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers 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 understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature of Patient, Parent or Guardian _____

Date _____

Patient's Dental History

NAME: _____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial denture
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- ☐ Your last cleaning ____/____
- ☐ Your last oral cancer screening ____/____
- ☐ Your last complete X-rays ____/____

Name of Previous Dentist:

City: _____ State: _____

Phone Number: (____) _____

Are you interested in whiter teeth?

- ☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

- ☐ Yes How Much _____
How Long _____
- ☐ No

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

One a scale of 1-10 with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit?

