# San Ramon Valley Cosmetic & Family Dentistry

2355 San Ramon Valley Blvd. Suite 103
San Ramon, CA 94583
**(925) 718-8483**

PATIENT'S NAME _____
LAST FIRST INITIAL

IF CHILD PATIENT'S NAME _____
LAST FIRST INITIAL

HOW DO YOU WISH TO BE ADDRESSED _____

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MINOR

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS: ADD. _____

TELEPHONE: RES. _____

CELL _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT: INSURANCE ☐ CREDIT CARD ☐ CASH

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU: _____

_____

DATE _____ DATE OF BIRTH _____

AGE _____

**DENTAL INSURANCE 1ST COVERAGE**

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DRIVERS LICENSE # _____

**DENTAL INSURANCE 2ND COVERAGE**

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DRIVERS LICENSE # _____

**RELEASE:**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

I understand a 20% cancellation fee will be charged for cancellation of procedures with the doctors, without 48 hours notice, and a $40.00 broken appointment fee for the cancellation or change to my cleaning appointments with the hygienist.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

## REGISTRATION

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PATIENT'S NAME _____ _____ _____ _____
*Last* *First* *Initial* *Date of Birth*

1. Purpose for initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____

CIRCLE THE APPROPRIATE ANSWER

6. Have you made regular visits? ..... YES NO
How often? _____
7. Were dental x-rays taken? ..... YES NO
8. Have you lost any teeth? ..... YES NO
Why? _____
9. Have they been replaced? ..... YES NO
10. How have they been replaced?
   a. Fixed bridge _____ Age _____
   b. Removable bridge _____ Age _____
   c. Denture _____ Age _____
11. Are you happy with the replacements? ..... YES NO
If no, explain _____
12. Would you like to know about permanent replacements? ..... YES NO
13. Have you ever had any problems or complications with previous dental treatment? ..... YES NO
If yes, explain _____
14. Do you clench or grind your teeth? ..... YES NO
15. Does your jaw click or pop? ..... YES NO
16. Have you experienced any pain or soreness in the muscles of your face or around your ear? ..... YES NO
17. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
18. Does food get caught between your teeth? ..... YES NO
19. Are any of your teeth sensitive to hot _____ cold _____ sweets _____ pressure _____
20. Do your gums bleed or hurt? ..... YES NO
When? _____
21. How often do you brush your teeth? _____ When _____
22. Do you use dental floss? ..... YES NO
How often? _____
23. Are any of your teeth loose, tipped or shifted? ..... YES NO
24. Do you have any discolored teeth that bother you? ..... YES NO
25. Do you feel your breath is offensive at times? ..... YES NO
26. Have you ever had gum treatment or surgery? ..... YES NO
What _____
Where _____
When _____
27. How do you feel about your teeth in general? _____
28. Are you happy with the appearance of your teeth? ..... YES NO
29. Have you had any unpleasant dental experiences or anything about dentistry that you strongly dislike? _____
30. Do you have any questions or concerns? ..... YES NO

**COMMENTS**

*I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.*

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

# DENTAL HISTORY

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PATIENT'S NAME _____ _____ _____ _____
*Last* *First* *Initial* *Date of Birth*

CIRCLE THE APPROPRIATE ANSWER

**COMMENTS**

1. Physician's Name _____ Address _____

2. Have you ever had a serious illness or operation? ..... YES NO
   If so, explain _____

3. Are you under a physician's care? ..... YES NO
   For what reason? _____

4. When was your last complete physical exam? _____
5. Are you taking any medication? ..... YES NO
6. Do you routinely take health related substance? ..... YES NO
7. Do you have any allergies? ..... YES NO
8. Are you allergic to any medications or substances? ..... YES NO
9. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
10. Have you taken Phen-fen? ..... YES NO
11. Are you allergic to Latex? ..... YES NO
12. Have you been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Are you aware of any heart murmurs? ..... YES NO
15. Have you ever had rheumatic fever? ..... YES NO
16. Have you ever had surgery, radiation treatment, chemo treatment for a tumor, growth or other condition? ..... YES NO
17. Do you have high or low blood pressure? ..... YES NO
18. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
19. Do you have any artificial joints/prosthesis? ..... YES NO
20. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
21. Have you ever bled excessively after being cut or injured? ..... YES NO
22. Do you have any stomach problems? ..... YES NO
23. Do you have any kidney problems? ..... YES NO
24. Do you have any liver problems? ..... YES NO
25. Are you diabetic? ..... YES NO
26. Do you have asthma? ..... YES NO
27. Do you have epilepsy or seizure disorders? ..... YES NO
28. Do you or have you had veneral disease? ..... YES NO
29. Do you have AIDS? ..... YES NO
30. Have you ever had hepatitis? ..... YES NO
31. Do you or have you had T.B.? ..... YES NO
32. Do you smoke? ..... YES NO
33. Do you consume alcoholic beverages? ..... YES NO
34. Are you pregnant or suspect that you might be? ..... YES NO
35. Do you have any disease, condition, or problem not listed? If so, explain _____
36. Is there anything else we should know about your health that we have not covered in this form? _____
37. Would you like to speak to the Doctor privately about any problems? ..... YES NO

*I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.*

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

# MEDICAL HISTORY