SOUTH COAST METRO

CENTER FOR DENTISTRY & IMPLANTS

Name _____ Soc. Sec. # _____
Last Name First Name Middle

Address _____ Sex ___ M ___ F Birthdate _____

City _____ State _____ Zip _____ Email _____

Cell Phone _____ Home Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Relationship _____ Phone _____

Alternate Phone _____ Email _____

Employer Information

Patient Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. #_____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber's # _____ Contract # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? __ Yes __ No

Subscriber's Name _____ Relation to patient_____ Birthdate_____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber's # _____ Contract # _____

Name(s) of other dependents under this plan _____

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Phone _____ Dentist's Email _____

Date of last care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had 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? _____ How often do you 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 Please explain_____

Medical History

Physician's Name _____ Address _____

Phone _____ Email _____

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 approx. date(s) _____

Do you or **have you ever** taken bisphosphonate medications for osteoporosis, cancer, or multiple myeloma such as (Fosamax, Actonel, Boniva, Reclast, Aredia, or Zometa)? __ Y __ N If so, for how long (months or years) _____

Women: Are you pregnant? __ Y __ N Nursing? __ Y __ N Taking birth control? __ Y __ N

Check **Y** for yes or **N** for no if you <u>have</u> or <u>have not</u> had 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 fever
__ Y __ N 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 of malfunction
__ Y __ N Tobacco habit
__ Y __ N Tonsillitis
__ Y __ N Tuberculosis
__ Y __ N Ulcer/Colitis
__ Y __ N Venereal disease

List medications you are currently taking, if any:

_____

_____

_____

Are you allergic to the following:

__ Penicillin __ Keflex __ Clindamycin __ Other

__ Aspirin __ Vicodin __ Codeine __ Motrin

Other Allergies _____

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.

Signature _____ Print Name _____ Date _____