DENTAL CARE OF FREMONT

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Welcome

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1. About You

Name _____
Preferred Name _____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Birthdate _____ Age _____ SS# _____
Address _____
City _____ State _____ Zip _____
Email _____
Home #_____ Work #_____
Mobile # _____ Fax #_____
Whom may we thank for referring you? _____
Other friends or family members seen here_____
_____
Employer _____ Employer ph # _____
Employer Address _____
City _____ State _____ Zip _____
How long were you employed there? _____

2. Account Info

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation_____
Home #_____ Work #_____
Mobile #_____Birthdate ____/____/_____
Email_____
Billing Address _____
City _____ State _____ Zip _____

3. Spouse/Significant Other

Name_____ Relationship_____
Home # _____ Work #_____
Mobile # _____Birthdate ____/____/_____

4. Insurance

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group #_____
Insured's Name _____Relation_____
Insured's Birthdate _____Insured's ID# _____
Insured's Employer _____Insured's Ph# _____

SECONDARY INSURANCE

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group #_____
Insured's Name _____Relation_____
Insured's Birthdate _____Insured's ID# _____
Insured's Employer _____Insured's Ph# _____

5 a. Medical History

Do you have a personal physician?
Physician's Name _____
Phone # _____ Last visit date_____
Are you currently under the care of a physician?
Please explain _____
_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____
Home # _____ Work #_____

Thank you for filling out this form completely.
It will allow us to serve you more effectively.
If you have a question at any time, please ask us.
We are more than happy to help!

5 b. Medical History

Your current physical condition ☐ Good ☐ Fair ☐ Poor

Do you smoke or used tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription / Over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one _____

_____

_____

_____

Have you ever taken Phen-fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If yes, when? _____

FOR WOMEN ONLY

Are you taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week #_____
Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes/ Fever Blisters
Yes	No	Alcohol / Drug abuse	Yes	No	High blood pressure
Yes	No	Anemia	Yes	No	HIV+ / AIDS
Yes	No	Arthritis	Yes	No	Hospitalized for any reason
Yes	No	Artificial bones, joints, or valves	Yes	No	Kidney problems
Yes	No	Asthma	Yes	No	Liver disease
Yes	No	Blood transfusion	Yes	No	Low blood pressure
Yes	No	Cancer/ Chemotherapy	Yes	No	Lupus
Yes	No	Colitis	Yes	No	Mitral Valve Prolapse
Yes	No	Congenital Heart Defect	Yes	No	Pacemaker
Yes	No	Diabetes	Yes	No	Psychiatric problems
Yes	No	Difficulty breathing	Yes	No	Radiation treatment
Yes	No	Emphysema	Yes	No	Rheumatic / Scarlet fever
Yes	No	Epilepsy			
Yes	No	Fainting spells	Yes	No	Seizures
Yes	No	Frequent headaches	Yes	No	Shingles
Yes	No	Glaucoma	Yes	No	Sickle cell disease
Yes	No	Hay fever	Yes	No	Sinus problems
Yes	No	Heart Attack	Yes	No	Stroke
Yes	No	Heart Murmur	Yes	No	Thyroid problems
Yes	No	Heart Surgery	Yes	No	Tuberculosis
Yes	No	Hemophilia	Yes	No	Ulcers
Yes	No	Hepatitis	Yes	No	Venereal Disease

Please list any medical condition(s) that you have ever had

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No	Aspirin	Yes	No	Latex
Yes	No	Codeine	Yes	No	Penicillin
Yes	No	Dental Anesthetics	Yes	No	Tetracycline
Yes	No	Erythromycin	Yes	No	Other
Yes	No	Jewelry / Metals			

Please list any other drugs/materials that you are allergic to

_____

_____

6. Dental History

Why have you come to the dentist today?_____

_____

_____

Date of last dental visit_____

Has your doctor or dentist ever told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experienced pain / discomfort in you jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss?_____
How many times a day do you brush? _____
Type of toothbrush bristles ☐ Hard ☐ Medium ☐ Soft

7. Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full or for charges incurred is not made, I agree to pay all costs of collection including a 50% collection fee, attorney fees and court costs.

_____

Signature **Date**

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

DENTAL CARE OF FREMONT

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials_____ Date_____
Doctor's comments _____

MEDICAL HISTORY UPDATE

Date_____ **Comments**_____ **Signature** _____

Date_____ **Comments**_____ **Signature** _____

Date_____ **Comments**_____ **Signature** _____