Dr. Ray Padilla
State of the Art, From the Heart

PATIENT'S INFORMATION

Mr./Mrs./Ms./Dr. (please circle one)

1. Patient's Name: _____
   Last First Middle Initial
2. Patient's Address: _____
   Street
   _____
   City State Zip
3. Patient's Phone: _____
   Home Work
4. Cell #: _____
5. E-mail Address: _____
6. Patient's Date of Birth: _____ / _____ / _____
   (MM) (DD) (YYYY)
7. Patient's Employer: _____
   Name (business name if self-employed)
8. Patient's Occupation: _____
9. Patient's Social Security #: _____
10. Patient's Driver's License #: _____
11. Patient's Dental Insurance Carrier: _____
12. Group # _____ Member ID # _____

Spouse or Parent Info (please circle one)

13. Name: _____
    Last First Middle Initial
14. Address (if different) _____
    _____
    City State Zip
15. Cell #: _____
16. E-mail Address: _____
17. Date of Birth: _____ / _____ / _____
    (MM) (DD) (YYYY)
18. Employer: _____
    Name (business name if self-employed)
19. Occupation: _____
20. Dental Insurance Carrier: _____
21. Group # _____ Member ID# _____
22. Whom may we thank for referring you?
    (How did you hear about our office?)
    _____

Whom should we contact in case of an emergency? _____
Name Cell Phone Relationship

Person responsible for this account: _____

Billing Address (if different from above): _____
Street City State Zip

*Patients are always responsible for payment of their bill EVEN if they have dental insurance. I understand that 1 ½ % monthly finance charge (18% annually) will be added to all balances over 60 days. _

RELEASE AND ASSIGNMENT

I understand that a release of information, to include records of any treatments or examinations rendered, may be required to facilitate the billing and reimbursement directly to the dentist of the insurance benefits under which I am entitled. I hereby authorize the release of such information to my insurance company or companies.

Signature: _____ Date: _____ / _____ / _____

CONSENT FOR PROFESSIONAL SERVICES

I hereby authorize and request Ray R. Padilla D.D.S. and his auxiliaries to administer any treatment, medications, anesthetics, and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my case after discussion of the proposed treatment, alternatives, and implications. I understand that results are not guaranteed or warranted and cannot be guaranteed or warranted.

Signature: _____ Date: _____ / _____ / _____

HEALTH HISTORY

Patient's Name: _____Date of Birth: _____ / _____ / _____

Whom should we contact in case of an emergency? _____
Name Cell Phone Relationship

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No In the last three years, have you gone to the hospital or emergency room?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain:
   Date of last medical exam: _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II.HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No **for each**)

Yes / No Chest pain (angina)
Yes / No Shortness of breath
Yes / No Swollen ankles
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Fainting spells
Yes / No Vertigo

Yes / No Bruise easily
Yes / No Bleeding problems
Yes / No Recent weight loss
Yes / No Fever
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Frequent vomiting

Yes / No Difficulty swallowing
Yes / No Jaundice
Yes / No Frequent urination
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Joint pain or stiffness
Yes / No Sinus problems
Yes / No Acid Reflux or GERD

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No **for each**)

Yes / No Heart disease
Yes / No High blood pressure
Yes / No Heart attack
Yes / No Atrial fibrillation
Yes / No Pacemaker
Yes / No Heart defects
Yes / No Mitral valve prolapse
Yes / No Heart murmurs
Yes / No Prosthetic Valve
Yes / No Rheumatic fever
Yes / No Artificial joint
Yes / No Pre-med recommended?
Yes / No Pins, plates, and/or screws
Yes / No Seizures
Yes / No Stroke
Yes / No COPD

Yes / No Hospitalization / Surgeries
Yes / No Transplants
Yes / No Family history of diabetes
Yes / No Diabetes
Yes / No Diet controlled?
Yes / No Insulin controlled?
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Asthma
Yes / No Emphysema
Yes / No Tuberculosis
Yes / No Other lung disease
Yes / No Kidney or bladder disease
Yes / No Liver disease

Yes / No Hepatitis A, B, or C (please circle)
Yes / No Anemia
Yes / No Hemophilia or blood disorder
Yes / No Thyroid disease
Yes / No Osteoporosis
Yes / No AIDS/HIV
Yes / No Eating disorders
Yes / No Psychiatric care
Yes / No Alzheimer's
Yes / No Dementia
Yes / No Stomach problems or ulcers
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Sexually Transmitted Disease(s)
Yes / No Skin disease

IV. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
Yes / No Have you ever been pre-medicated for dental treatment due to a medical condition? If YES, why: _____
Yes / No Have you experienced any significant injury during the past year?
Yes / No Are you now being or have you ever been emotionally or physically abused by a family member, a spouse, or an intimate partner?
Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?
Yes / No Have you ever been diagnosed with Sleep Apnea or any other sleep disorder? If so, what? _____
If YES, have you been prescribed a CPAP, oral sleep appliance or other device for this condition? Yes / No (please circle)
If YES, do you currently use it (circle one): Each night / Intermittently / Never / Other: _____

V. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No **for each**)

Yes / No / Unknown Latex
Yes / No / Unknown Aspirin
Yes / No / Unknown Darvon
Yes / No / Unknown Codeine
Yes / No / Unknown Vicodin
Yes / No / Unknown Percodan

Yes / No / Unknown Demerol
Yes / No / Unknown Valium
Yes / No / Unknown Local anesthetic (Novocain or Xylocaine)
Yes / No / Unknown Penicillin
Yes / No / Unknown Amoxicillin

Yes / No / Unknown Erythromycin
Yes / No / Unknown Clindamycin
Yes / No / Unknown Tetracycline
Yes / No / Unknown Sulfa
Yes / No / Unknown Nitrous Oxide
Other: _____

VI. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST TWELVE MONTHS?

(Please circle Yes or No **for each**)

Yes / No Prescription medications
Yes / No High blood pressure medicine
Yes / No Drugs for heart problems
Yes / No Nitroglycerin
Yes / No Anticoagulants (Coumadin)
Yes / No Aspirin
Yes / No Phen-Fen

Yes / No Insulin, Orinase, or similar drugs
Yes / No Cortisone (Steroids)
Yes / No Bisphosphonates
Yes / No Fosamax
Yes / No Boniva
Yes / No Actonel
Yes / No Tranquilizers

Yes / No Antibiotics
Yes / No Zometa
Yes / No Over-the-counter medicines
Yes / No Tobacco in any form
Yes / No Recreational drugs
Yes / No Alcohol
Yes / No Herbal Supplements

Please provide the name of any other medication you may be taking that's not listed above: _____

_____

Do you have any history of substance abuse? If YES, please describe: _____

_____

VII. WOMEN ONLY (Please circle Yes or No **for each**)

Yes / No Are you or could you be pregnant? If YES, how many months? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VIII. DENTAL HEALTH HISTORY

PLEASE MARK ANY QUESTIONS THAT YOU WOULD ANSWER "YES"

When was your last visit to a dental office & for what treatment? _____

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Does food become lodged easily between your teeth?
- ☐ Do you have difficulty chewing your food?
- ☐ Do you avoid brushing any part of your mouth because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do your gums feel swollen or tender?
- ☐ Have you ever noticed slow-healing sores in or about your mouth?
- ☐ Are your teeth sensitive to:
  - ☐ Hot foods or liquids?
  - ☐ Cold foods or liquids?
  - ☐ Sweets?
  - ☐ Bite pressure?
- ☐ Are you dissatisfied with the appearance of your teeth?
- ☐ Are you seeking comprehensive dental care?
- ☐ Do you brush at least twice a day?
- ☐ Do you floss at least once a day?
- ☐ Do you have pain in the face, cheeks, jaw, joints, throat or temples?
- ☐ Do you clench or grind your jaw frequently; does it "pop" when you open or close your mouth?
- ☐ Does your jaw get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have any jaw symptoms or headaches upon waking in the morning?
- ☐ Do you take medication or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Have you had any trauma to the jaw?
- ☐ Do you have any disease, condition, or problem not listed previously that you feel we should know about?
  If so, please describe: _____

  _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically Compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____ / _____ / _____

Physician's Name: _____ Phone Number: _____

Type of Specialty: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACE SHEET

I acknowledge that I have read a copy of the Dental Materials Fact Sheet dated May 2004, as required by law.

_____
Patient Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
Patient Initials

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers
- ☐ An emergency situation
- ☐ Other (please specify)

CONSENT FOR COMMUNICATION

Email Consent (Please check mark your preference)

*We do not sell, advertise or disclose emails (or records) to any third-party company. This information is solely only used in the interest of communicating with the patient regarding dental/health care, appointments, insurance, finances and records, etc.

_____ I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time. My email address is _____.

_____ I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is _____.

_____ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

I certify that I have read and understand all these forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, contact information and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any reason or omissions that I may have made in the completion of this form.

_____ _____ / _____ / _____ _____ _____ / _____ / _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date