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: ________________________________
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) ________________________________
    ____
    Street City State Zip
15. Cell #: ________________________________
16. E-mail Address: ________________________________
17. Date of Birth: ________________________________
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?
    ____
    Name

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

Party 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: ______________

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 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 Surgeries
Yes / No Hospitalization
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
Yes / No Anemia
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 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? 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?

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

Please list others:
____
____

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"

- ☐ 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: _________________________________

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

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.

____
Please Print Name

____
Signature

I certify that I have read and understand this form. 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 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

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)