

ALHAMBRA DENTAL GROUP

PATIENT INFORMATION FORM

Patient's Name: Mrs., Mr., Ms. _____ Date of Birth _____ Age _____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY SHOULD FILL OUT EMPLOYMENT INFORMATION

Parent or Guardian's Name (if minor) _____

Residence Address _____

How Long _____ Email _____ Fax _____

City _____ State _____ Zip _____ Phone _____ Cell Phone _____

Occupation (Parent/Guardian) _____ Employer _____ Phone _____

Employer Address _____

Spouse's Name _____ Phone _____ Cell Phone _____

Spouse's Occupation _____ Employer _____ Phone _____

Employer's Address _____

Person financially responsible _____ Relation to you _____

Social Security Number (Mr.) _____ Children – Names & Ages _____

(Ms.) _____

Do you wish to have a relative or friend assist you in the decision making of your dental treatment?

If Yes, Name: _____ Phone Number _____

If No, **PATIENT'S SIGNATURE:** _____

Previous Dentist _____ Date of most recent visit/procedure _____

Emergency Contact (name): _____ Relationship _____ Phone _____

We always want to express our special appreciation to patients who refer others to us.
Please indicate below how you came to know about us.

Name _____

Physician/Dentist Friend/Relative Other source of Referral _____

Dental Benefits Assignment

PAYMENT IS DUE IN FULL AT TIME APPOINTMENT FOR SERVICES ARE SCHEDULED

Dental Benefits Carrier _____ Secondary Carrier _____

If Patient is a student – Name of School _____

NOTE: We do not pre-authorize treatment. We will provide you with an estimate of benefits based on available information and previous experience with your plan.

I hereby assign dental benefits to the Alhambra Dental Group and authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my dental plans. This release is solely for the purpose of facilitating the billing reimbursement, directly to the doctor, or dental benefits to which I am entitled.

Signature of Patient/Parent or Guardian

Signature of Insured Party

We are concerned with your oral health as well as your total well-being. An essential part of our approach is a thorough health history. Please fill out the following health questionnaires completely. Thank You.

1. Name, address, and phone number of family physician. _____

2. YES NO Are you now under current medical treatment? If yes explain

3. Do you now have, or ever had any of the following: (for each item please WRITE: YES or NO, do not leave any blanks and do not cross a line through any items).

- | | | | |
|---|---|--|--|
| a. <input type="checkbox"/> Hepatitis/liver disease | j. <input type="checkbox"/> Rheumatic Fever | s. <input type="checkbox"/> Elevated Cholesterol | bb. <input type="checkbox"/> Dry Mouth |
| b. <input type="checkbox"/> Thyroid | k. <input type="checkbox"/> Rheumatism or Arthritis | t. <input type="checkbox"/> Shortness of Breath | cc. <input type="checkbox"/> Osteoporosis |
| c. <input type="checkbox"/> Heart Ailment | l. <input type="checkbox"/> Tumors or Growths | u. <input type="checkbox"/> Prolonged Bleeding | dd. <input type="checkbox"/> Acid Reflux |
| d. <input type="checkbox"/> High Blood Pressure | m. <input type="checkbox"/> Any Blood Diseases | v. <input type="checkbox"/> Venereal Diseases | ee. <input type="checkbox"/> Have you ever been diagnosed with Mononucleosis? |
| e. <input type="checkbox"/> Lung Disease/TB | n. <input type="checkbox"/> Any Kidney Disease | w. <input type="checkbox"/> Mental Disability | ff. <input type="checkbox"/> Have you ever been diagnosed with Epstein-Barr virus? |
| f. <input type="checkbox"/> Diabetes | o. <input type="checkbox"/> Stomach or Intestinal Disease | x. <input type="checkbox"/> Chicken Pox | |
| g. <input type="checkbox"/> Stroke/Heart Attack | p. <input type="checkbox"/> Heart Valve Abnormality | y. <input type="checkbox"/> HIV + | |
| h. <input type="checkbox"/> Physical Disability | q. <input type="checkbox"/> Phen Phen use | z. <input type="checkbox"/> Psychiatric Treatment | |
| i. <input type="checkbox"/> Spinal Bifida | r. <input type="checkbox"/> Aphasia (problems swallowing or breathing). | aa. <input type="checkbox"/> Cancer—Type & Date: _____ | gg. Sleep Apnea |

- CPAP _____
- Oral Appliance _____
- Sleep Study _____

OTHER: _____

4. Chief Complaint: _____

YES ___ NO ___ 5. Have you had any operations or prosthetic implants (e.g. hip or heart valve, etc.)? If yes, please explain: _____

YES ___ NO ___ 6. Are you allergic to any known materials or solutions? Iodine/Seafood _____, Acrylic _____, Latex _____, Talcum Powder _____, Medication (name) _____, OTHER: _____

YES ___ NO ___ 7. Are you now taking drugs, medications, or herbal health supplements? If yes, please list name, and dosage _____

YES ___ NO ___ 8. Have you ever used recreational drugs?

YES ___ NO ___ 9. Have you ever Hyperventilated or suffered from episodes of Hypoglycemia?

YES ___ NO ___ 10. Do you have a history of fainting or convulsions?

YES ___ NO ___ 11. Have you ever had any X-ray treatments (other than diagnostics)?

YES ___ NO ___ 12. Have you ever had an adverse response to anesthetics in any form? If yes, please Explain: _____

YES ___ NO ___ 13. Are you now pregnant, or may be in the near future? If yes, how many months? _____

YES ___ NO ___ 14. Do you have asthma, hay fever, frequent sore throats or sinusitis?

YES ___ NO ___ 15. Does your diet include *excessive*: (1) sugary foods _____ (2) citric foods _____ (3) hard/crunchy foods _____.

YES ___ NO ___ 16. Are you especially afraid of “shots”, we specialize in cowards.

YES ___ NO ___ 17. Do you require pre-medication prior to dental treatment, due to a heart condition or rheumatic fever?

YES ___ NO ___ 18. Do you mouth breathe?

YES ___ NO ___ 19. Have you ever been told you have “TMJ” (jaw joint) problems or had your bite adjusted?

