



WELCOME



Patient Information

Date _____

SS/HIC/Patient ID# _____

Patient Name _____

Address _____

City _____

State _____

ZIP _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Spouse/Partner Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance CO. _____

Group # _____

Is the patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthday _____

Relationship to Patient _____

Insurance Company _____

Group # _____

ASSIGNMENT AND RELEASE

I certify and I, and/or my dependent(s), have Insurance coverage with _____ and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext. _____ Cell phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work (_____) _____ Ext. _____

Dental Arts Group
707 Arlene Ave.
El Cajon, CA. 92020
(619) 444-1001

Reason for today's visit	Chew on one side of mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Former Dentist	Clicking or popping jaw	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
City/State	Dry mouth	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Date of last dental visit	Fingernail biting	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No
Date of last dental X-rays	Food collection between the teeth	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Foreign objects	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
	Grinding teeth	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Bad breath	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No	Sensitivity when biting
Bleeding gums	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Sores or growths in your mouth
Blisters on lips or mouth	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	How often do you floss?
Burning sensation on tongue	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	How often do you brush?

HEALTH HISTORY

Medical Physician's Name _____

Date of last Visit: _____

Have you even taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Lnimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐Yes ☐No

Have you ever taken **Bisphosphonates**: (Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, and Zometa) ☐Yes ☐No

AIDS/HIV	☐ Yes ☐ No	Cortisone treatments	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Cough persistent or bloody	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mitral Valve Pressure	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding abnormally with extractions or surgery	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Do you wear Contact Lenses	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No		

Women: Taking birth control pills? ☐Yes ☐No Are you pregnant? ☐Yes ☐No Due date _____ Are you nursing? ☐Yes ☐No

Medications: List any medications you are currently taking and the correlating diagnosis:

Allergies:

☐ Aspirin	☐ Codeine	☐ Latex	☐ Penicillin	☐ Other _____
☐ Barbiturates (sleeping pills)	☐ Iodine	☐ Local Anesthetic	☐ Sulfa	

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____