836 Second Street
Encinitas, CA 92024
(760) 753-6448

2335 E. Valley Pkwy.
Escondido, CA 92027
(760) 741-9693

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Patient's Sex: ☐ F ☐ M

Name_____ Birth date _____ Home Phone _____

Address_____ City _____ State_____ Zip _____

Email _____ Cell Phone_____

Do prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone ☐ Text ☐ Email

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College_____ City_____ State_____ ☐ Full time ☐ Part time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address_____ City_____ State_____ Zip _____

Spouse or Parent/Guardian's Name_____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient_____

Email _____ Cell Phone_____

Driver's License#_____ Birth date _____

Employer_____ Work Phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient_____

Birth date SS#/SIN _____ Date Employed_____

Employer_____ Work Phone _____

Address of Employer_____ City_____ State_____ Zip _____

Insurance Company_____ Group # _____ Policy/ID# _____

Address of Ins. Co._____ City_____ State_____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient_____

Birth date SS#/SIN _____ Date Employed_____

Employer_____ Work Phone _____

Address of Employer_____ City_____ State_____ Zip _____

Insurance Company_____ Group # _____ Policy/ID# _____

Address of Ins. Co._____ City_____ State_____ Zip _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you have or have you had any of the following?		

	Yes	No
8. Are you allergic to any of the following?		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
10. Women Only		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implants	☐	☐	Diarrhea or Vomitting	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
What is your main concern? _____		
Are you experiencing any pain or discomfort in your teeth and gums?	☐	☐
Any discomfort in your jaw?	☐	☐
Are you interested in cosmetic dentistry?	☐	☐
Are you interested in orthodontic treatment?	☐	☐

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

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

Signature of patient (or parent/guardian if minor) Date