ROCKLIN FAMILY DENTAL GROUP

Date:

Patient Information

Name:			Date of Birth:	Sex: ❒ Male ❒ Female
Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Partnered for _____ Years				SSN:
Home Phone:	Additional Phone:		Email Address:	
Address:		City:	State:	Zip Code:
Employer / School:			Employer / School Phone:	
Employer / School Address:		City:	State:	Zip Code:
Spouse or Parent's Name:		Employer:		Work Phone:
Person to Contact In Case of Emergency:		Phone Number:		Relationship:
Whom May We Thank For Referring You?				

Responsible Party

Name of Person Responsible for This Account:		Relationship to Patient:
Address:		Home Phone:
Driver's License Number:		Date of Birth:
Employer:		Work Phone:
Current Patient: ❒ Yes ❒ No	Email Address:	Cell Phone:

Insurance Information

Name of Insured:			Relationship to Patient:	
Date of Birth:	SSN:		Date Employed:	
Employer:			Work Phone:	
Employer Address:		City:	State:	Zip Code:
Insurance Company:		Group #:	Union or Local #:	
Insurance Company Address:		City:	State:	Zip Code:
Do You Have Additional Insurance? ❒ Yes ❒ No				

– Please Turn Over –

Dental History

Reason for Today's Visit:	Date of Last Dental Visit:	What was Done?
Are You Interested in **Whitening** or **Straightening** Your Teeth?	Would you Like to Change the Appearance of Your Smile?	

Check if You Have Had Any of the Following:

- ❒ Bad Breath
- ❒ Bleeding Gums
- ❒ Clicking or Popping Jaw
- ❒ Food Collection Between the Teeth
- ❒ Dental Trauma
- ❒ Grinding Teeth
- ❒ Loose Teeth or Broken Fillings
- ❒ Periodontal Treatment
- ❒ Orthodontic Treatment
- ❒ Wisdom Tooth Removal
- ❒ Sensitivity to Temperature
- ❒ Sensitivity to Sweets
- ❒ Sensitivity When Biting
- ❒ Sores or Growths in Your Mouth

Medical History

Physician's Name:	Date of Last Visit:

Have You Ever Had Any Serious Illnesses or Operations? ❒ Yes ❒ No If Yes, Describe:

Have You Ever Had a Blood Transfusion? ❒ Yes ❒ No If Yes, Give Approximate Dates:

Are You Or Were you On Fosamax Or Other Osteoporosis Medications? ❒ Yes ❒ No

(Women) Are You Pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking Birth Control Pills? ❒ Yes ❒ No

Check if You Have Had Any of the Following:

- ❒ AIDS
- ❒ Anemia
- ❒ Arthritis, Rheumatism
- ❒ Artificial Heart Valves
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Back Problems
- ❒ Blood Disease
- ❒ Cancer
- ❒ Chemical Dependency
- ❒ Chemotherapy
- ❒ Circulatory Problems
- ❒ Cortisone Treatments
- ❒ Cough, Persistent
- ❒ Cough Up Blood
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Fainting
- ❒ Glaucoma
- ❒ Headaches
- ❒ Heart Murmur
- ❒ Heart Problems
  Describe: ___________
- ❒ Hemophilia
- ❒ Hepatitis A
- ❒ Hepatitis B
- ❒ Hepatitis C
- ❒ High Blood Pressure
- ❒ HIV Positive
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Metal Sensitivity From Jewelry
- ❒ Mitral Valve Prolapse
- ❒ Nervous Problems
- ❒ Pacemaker
- ❒ Phen/Fen (Ever Taken?)
- ❒ Psychiatric Care
- ❒ Radiation Treatments
- ❒ Respiratory Disease
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Shortness of Breath
- ❒ Skin Rash
- ❒ Sleep Apnea
- ❒ Stroke
- ❒ Swelling of Feet or Ankles
- ❒ Thyroid Problems
- ❒ Tobacco Habit
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Ulcer
- ❒ Venereal Disease
- ❒ Other ___________________

Medications	Allergies
______________________________	
______________________________	
______________________________	
______________________________	

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I hereby authorize the doctor or staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis or my dental needs. I also authorize the doctor or staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

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Signature of Patient or Parent (if Minor) *Date*

Reviewed: Initial: -------- Date: -------- *Reviewed:* Initial: -------- Date: -------- *Reviewed*: Initial: -------- Date: --------