Del Lago
DENTAL GROUP

Date _____ **PATIENT INFORMATION AND HEALTH HISTORY**

HOW DID YOU FIND OUT ABOUT OUR OFFICE?_____

PERSONAL INFORMATION

PATIENT NAME_____
FIRST MIDDLE LAST

PATIENT DATE OF BIRTH _____ PATIENT SS# _____-_____-_____

HOME ADDRESS_____ HOME PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ BUS. PHONE ( ) _____ ext____

PATIENT EMPLOYED BY_____ CELL PHONE ( ) _____

BUSINESS ADDRESS _____ CITY _____ ZIP _____ E-MAIL _____

NEAREST RELATIVE/
EMERGENCY CONTACT _____ PHONE ( ) _____ CELL ( ) _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES? YES _____ NO _____
(If no skip to dental information)

DENTAL INSURANCE INFORMATION

NAME OF YOUR DENTAL INSURANCE COMPANY _____ Gp# _____

NAME OF SUBSCRIBER _____ YOUR RELATIONSHIP TO SUBSCRIBER SPOUSE ❑ CHILD ❑ SELF ❑

SUBSCRIBER DATE OF BIRTH _____ INSURED SS# _____-_____-_____

EMPLOYER_____ BUS. PHONE ( ) _____

BUSINESS ADDRESS _____ CITY _____ ZIP _____

SECONDARY DENTAL INSURANCE COMPANY

NAME OF INSURANCE COMPANY _____ Gp# _____

NAME OF INSURED_____

INSURED DATE OF BIRTH _____ INSURED SS# _____-_____-_____

INSURED EMPLOYER _____ BUS. PHONE ( ) _____

DENTAL INFORMATION

DO YOUR GUMS BLEED WHEN YOU BRUSH/OR FLOSS? YES _____ NO _____

DO YOU HAVE CHRONIC BAD BREATH? YES _____ NO _____

ARE YOUR TEETH SENSITIVE TO HEAT OR COLD? SWEETS? OR BITING DOWN? YES _____ NO _____

DO YOU GRIND OR CLENCH YOUR TEETH? YES _____ NO _____

HAVE YOU EVER HAD A BAD DENTAL EXPERIENCE? YES _____ NO _____

DATE OF LAST EXAMINATION _____ DATE OF LAST X-RAYS _____

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? WOULD YOU LIKE TO IMPROVE THEM? _____

_____

HOW WOULD YOU DESCRIBE YOUR CURRENT DENTAL PROBLEM?_____

_____

HOW WOULD YOU LIKE TO SEE US CORRECT YOUR DENTAL PROBLEM?

_____

_____

For your health's sake, you must be accurate:

Physician Name_____

Phone _____ **MEDICAL HISTORY**

CIRCLE

1. Have you been a patient in the hospital during the past two years? _____ YES NO
2. Have you been under the care of a medical doctor during the past two years? _____ YES NO
3. Have you taken Phen-Fen during the past two years?_____ YES NO
4. Have you had an EKG? _____ YES NO
5. Have you ever been advised to pre-medicate prior to dental treatment?_____ YES NO
6. Are you allergic to penicillin, aspirin, codeine, latex or other (please circle or list)? _____
7. List any medications you are taking_____
8. Have you ever had excessive bleeding requiring special treatment? _____ YES NO
9. Circle yes or no for each of the following which you have had or have at present.

Heart Failure	YES	NO	Ulcers	YES	NO	AIDS	YES	NO
Heart Disease or Attack	YES	NO	Emphysema	YES	NO	Hepatits A (infectious)	YES	NO
Angina Pectoris (Chest Pains)	YES	NO	Chronic Bronchitis	YES	NO	Hepatitis B (serum)	YES	NO
High Blood Pressure	YES	NO	Tuberculosis	YES	NO	Liver Disease	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO	Blood Transfusion	YES	NO
Rheumatic/Scarlet Fever	YES	NO	Hay Fever/Sinus Trouble	YES	NO	Drug or Alcohol Abuse	YES	NO
Conginital Heart Lesions	YES	NO	Allergies or Hives	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Diabetes	YES	NO	VD (Syphilis, Gonorrhea)	YES	NO
Mitral Valve Prolapse (MVP)	YES	NO	Thyroid Disease	YES	NO	Cold Sores	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Genital Herpes	YES	NO
Heart Surgery	YES	NO	Chemo (Cancer, Leukemia)	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Joints	YES	NO	Arthritis	YES	NO	Fainting or Dizzy Spells	YES	NO
Anemia	YES	NO	Cortisone Medicine	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Glaucoma	YES	NO	Psychiatric Treatment	YES	NO
Kidney Trouble	YES	NO	Pain in Jaw Joints	YES	NO	Bruise Easily	YES	NO

10. Do you ever wake up from sleep short of breath? _____ YES NO
11. Are you on a special diet? _____ YES NO
12. Has your medical doctor ever said you have a cancer or tumor?_____ YES NO
13. Do you have any disease, condition or problem not listed? _____ YES NO
14. WOMEN: Are you pregnant now? _____ YES NO
    Do you anticipate becoming pregnant?_____ YES NO
    Are you taking birth control? _____ YES NO

Please be advised that many antibiotics may lessen the effects of oral contraception.

Please describe 'yes' answers _____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I understand that the doctor reserves the right to charge $100.00 for appointments cancelled or broken without 24 hour advance notice.

DATE _____ SIGNATURE _____

I hereby grant complete authority to Dr. Day to administer any treatment and to administer such x-rays, anesthetics, and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.

DATE _____ SIGNATURE _____

_____

_____