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(805)688-6495

Chart#: ____________________

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Title: ____________ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _______________ **SS#:** _______________ **Last Dental Appt:** _______________

Email Address: ____

Phone: _______________ _______________ _______________
Home Mobile Work

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ________ ____________
City State Zip Code

Please mark any allergies, medical conditions, or pre-med requirements:

☐ *Pre-Med - Amox	☐ *Pre-Med - Cephalexin	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems
☐ Stroke	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease			

If 'other' please describe:

____

____

How did you hear about us?

Internet Search

Yellow Pages

Social Media

Referral by:________________________

Other:____________________________

Are you currently taking any medications? Yes No

- [ ] Acetominophen
- [ ] Albuterol
- [ ] Amlodipine
- [ ] Amoxicillin
- [ ] *Antibiotic
- [ ] Aspirin
- [ ] Atrovostatin
- [ ] Benzodiazapine
- [ ] Bisphosphonate
- [ ] *Blood Pressure Med
- [ ] *Blood Thinner
- [ ] Buproprion
- [ ] Carvedilol
- [ ] *Cholesterol Med
- [ ] Citalopram
- [ ] Clindamycin
- [ ] Cyclobenzaprine
- [ ] Dextroamphetamine
- [ ] Duloxetine
- [ ] Fluticasone
- [ ] Furosemide
- [ ] Gabapentin
- [ ] Hydrochlorothyazide
- [ ] Ibuprofen
- [ ] Insulin
- [ ] Levothyroxine
- [ ] Lisinopril
- [ ] Lexapro
- [ ] Metformin
- [ ] Metoprolol
- [ ] Montelukast
- [ ] *Muscle Relaxant
- [ ] Omeprazol
- [ ] *Osteoperosis Med
- [ ] *Pain Relief
- [ ] Pantoprezol
- [ ] Prednisone
- [ ] Sertraline
- [ ] Simvastatin
- [ ] Trazodone
- [ ] Xanax
- [ ] Valium
- [ ] Other (Please indicate below)

Other medications:

____

____

Physician's Name and Number:

____

____

What is the main reason for your visit today?:

____

____

Do you or have you had any of the following dental conditions or treatments?:

- [ ] Pain
- [ ] Bleeding gums
- [ ] Sensitivity to cold/hot/sweets/pressure
- [ ] Dry mouth
- [ ] Gum disease
- [ ] Popping/Painful jaw (TMJ)
- [ ] Teeth grinding
- [ ] Cold sores
- [ ] Canker sores
- [ ] "Deep Cleaning"
- [ ] Braces/Clear aligners
- [ ] Teeth Whitening

Emergency Contact (Name, Number, Relationship)

____

____

✘ **Patient or Guardian Signature and Date**

______________________________ ______________

Patient Signature Date

Provider Signature and Date

______________________________ ______________

Provider Signature Date

Dental Insurance Information

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: __________ **ID #:** ______________ **Group #:** __________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ________
City State Zip Code

Insured's Employer Name: ______________________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ________
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ ________
City State Zip Code

Response Date: ____/____/________