First Name:______________________M.I _____

Last Name:_________________________________

Birth Date:____________________ Age:_________

Single Married Separated Divorced Widow

social security number ________-_________-__________

California I.D or Driver's License :___________________

Home Address:_______________________________APT.____

CITY_________________________STATE________ZIP__________

Home Phone: (______) _________-_______________

Responsible party's information:

Full Name : _________________________________

social security number ________-_________-__________

Relation to you : ___________________________

Employer Name:______________________________

Work Address: ______________________________

____

Work Phone: (___) ________-______________ ext ______

Name of dental insurance: _____________________

Emergency Contacts:

Name:_______________________________________

Phone Number:________________________________

Relation To You:______________________________

How did you Learn About Our Office ?

_____ By A Patient of Ours: (Please Name:)

____

____Walking by Noticed the office

____Received flyer in mail

____Flyers handed out to you

____Other Way,Please Explain:

____

Preferred language: English/ spanish / Other__

Smoking status:

Current Smoker / Former Smoker / Never Smoked

Ethnicity: Not Latino / Latino

Race:

American indian or Alaskan native / Asian / Black or African American / Caucasian / Pacific islander or native Hawaiian / Hispanic / Other

Height: _____Ft______ Inches **Weight;** ________Pounds

In Future you will have access to information that you provided us here , if interested please leave your Email address: _____________ @ ___________

Do You (or did you ever) Have:

No Pills or injections of the following drugs: (Normally used for osteoporosis or cancer) alendronate, Fosamax , ibandronate, Boniva, risedronate, Actonel, Atelvia, zoledronic acid Reclast , Bisphosphanates Yes

No Arthritis or Joint Problems Yes

No Artificial joints , heart valves or bone implants Yes

No Asthma or Emphysema Yes

No Anemia or any blood Problem Yes

No Abnormal or prolonged Bleeding Yes

No AIDS or HIV positive testing Yes

No Allergy To dental injections Yes

No Any Allergies To : Yes

Sulfa Aspirin Ibuprofen
Tylenol Penicillin Latex
Erythromycin Tetracycline Codeine

No Chest pain Yes

No Chemical Dependency Yes

No Cortisone Treatment Yes

No Cancer , Tumors , radiation or chemotherapy Yes

No Diabetes Yes

No Faintings oe dizziness Yes

No have you ever taken " 'Fen-phen" Yes

No Glaucoma Yes

No Migraine, Cluster Headaches or similar problems Yes

No High Blood Pressure Yes

No Heart disease or Heart Surgery Yes

No Heart Murmur or Heart Valve Problems Yes

No Heart attack or pacemaker Yes

No Hepatitis, jaundice or liver disease Yes

No Kidney problems Yes

No Low Blood Pressure Yes

No Mental or Psychiatric problems Yes

No Persistent coughing Yes

No Peptic ulcer or Gastritis Yes

No Respiratory disease Yes

No Rheumatic fever Yes

No Seizures, epilepsy, Neurologic disorders Yes

No Sexually transmitted diseases Yes

No Shortness of Breath Yes

No Swelling of feet or ankles Yes

No Stroke or similar Conditions Yes

No Tuberclosis Yes

No Thyroid problems Yes

No Unexplained weight loss or Excessive thirst Yes

For Women Only

No Are (or might) you be Pregnant? If yes,How Many Weeks? . . . . Yes

N0 Are You Nursing? Yes

No Any recent change in Your period? Yes

No Are You Taking Contraceptives? Yes

Please Explain if you answered "Yes" to any question or ~~if you have a medical condition or allergy not listed:~~

____

____

Please List All Medications You are taking :

____

____

Your Physician Name: ___________________________

Your Physician Number:__________________________

No have you had any tooth or gum pain recently? Yes

Please explain ________________________

____

____

No Do your gums bleed when you brush or floss? Yes

No Do you brush your teeth at least twice a day? Yes

No Do you wear any removable artificial teeth? Yes

When was the last time you visited a dentist? . . .

I Have Read This form and provided the information to the best of my knowledge.I understand that I might need several check-ups for complete diagnosis of all of my dental and oral diseases .If I have any dental insurance I agree all information to be released to my insurance company and payments to be made to this office. I Agree to submit to binding arbitration on any claims against this office, its employees and services.

Patient Or Parent(guardian) :

Date __________ Signature ________________

Morris Zad DDS