Just Smile

GALE RANCH DENTAL GROUP

NEWPARK MALL DENTAL GROUP

DENTAL GROUP

Premier Family Dentistry
Proudly Serving the Bay Area for over 28 years

ABOUT YOU

Today's Date: _____
Email Address: _____
Name: _____
I prefer to be called: _____ _____
Birth date: ____/____/____ Age: _____
SS#: _____
Home address: _____
City: _____ St. _____ Zip _____
Home Phone#: _____
Cell/Other#: _____
Work Phone#: (____) _____ Ext: _____
Driver's License#: _____

Marital Status:

❑ Single ❑ Married ❑ Partnered
❑ Divorce/Separated ❑ Widowed

Employer: _____
Occupation: _____
When and where are best times to reach you? _____
_____
Whom May we thank for referring you? _____
Others Family members seen by us? _____
Optional Info to help the doctor get to know you:
Your Special Interest/Hobbies: _____
How long have you lived in area? _____

SPOUSE INFORMATION

His/Her Name: _____
Employer: _____
Work Phone#: (____) _____ Ext: _____
SS#: _____
Birth date: ____/____/____ Age: _____
Driver's License#: _____

PRIMARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#: (____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/___/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

SECONDARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#: (____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/___/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

Authorization and Release:
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 costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of patient:

_____

Date:

_____

MEDICAL HISTORY

Do You Have a personal Physician? ❑ Yes ❑ No
Physician's Name:_____
Phone#:(_____)_____
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you had any metals rod, pins, or implants? ❑ Yes ❑ No
Are you taking any prescriptions/over the counter drugs? ❑ Yes ❑ No
Please List each One: _____
_____
_____

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No
Have you ever taken Phen-fen? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No

For Women Only

Are you using a prescribed method of birth control? ❑ Yes ❑ No
Are You Pregnant? Week#_____ ❑ Yes ❑ No
Are You Nursing? ❑ Yes ❑ No
Are you taking any birth control? ❑ Yes ❑ No

Have you ever had any of the followings diseases or medical problems?

Abnormal Bleeding	❑ Yes ❑ No	Herpes /Fever Blisters	❑ Yes ❑ No		
AIDS	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No		
Alcohol/Drug abuse	❑ Yes ❑ No	HIV	❑ Yes ❑ No		
Anemia	❑ Yes ❑ No	Hospitalized for any reason	❑ Yes ❑ No		
Arthritis	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No		
Artificial Bones/Joints/Valves	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No		
Asthma	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No		
Blood Transfusion	❑ Yes ❑ No	Lupus	❑ Yes ❑ No		
Cancer/Chemotherapy	❑ Yes ❑ No	Mitral Valve Prolapsed	❑ Yes ❑ No		
Colitis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No		
Congenital Heart Defect	❑ Yes ❑ No	Psychiatric Problems	❑ Yes ❑ No		
Diabetes	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No		
Difficulty Breathing	❑ Yes ❑ No	Rheumatic/Scarlet fever	❑ Yes ❑ No		
Emphysema	❑ Yes ❑ No	Seizures	❑ Yes ❑ No		
Epilepsy	❑ Yes ❑ No	Shingles	❑ Yes ❑ No		
Fainting Spells	❑ Yes ❑ No	Sickle Cells Disease/Traits	❑ Yes ❑ No		
Frequent Headache	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No		
Glaucoma	❑ Yes ❑ No	Stroke	❑ Yes ❑ No		
Hay Fever	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No		
Heart Attack/Surgery	❑ Yes ❑ No	Tuberculosis (TB)	❑ Yes ❑ No		
Heart Murmur	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No		
Hemophilia	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No		
Hepatitis	❑ Yes ❑ No				

Please List any serious medical condition(s) that you ever had:

_____
_____
_____

Medications:

List Medications (Prescribed/etc) you are currently taking:

_____
_____
_____

Are you allergic to any of the following:

Aspirin	❑ Yes ❑ No	Jewelry Metals	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No
Dental Anesthetics	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Other	❑ Yes ❑ No

Please list any drugs /materials that you are allergic to:

_____
_____
_____

DENTAL HISTORY

Reason For Today's Visit:_____
_____
Former Dentist:_____
Address:_____
Date Of Last Dental Visit:_____
Date Of Last Dental X-rays:_____
Your Current dental health is ❑ Good ❑ Fair ❑ Poor
Are You currently In Pain? ❑ Yes ❑ No
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No
Have you ever had Periodontal Disease? ❑ Yes ❑ No
Do You now or have ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ? ❑ Yes ❑ No
Are your teeth sensitive to sweets,heat,cold or anything else? ❑ Yes ❑ No
Are your teeth sensitive when biting? ❑ Yes ❑ No
Do you have sores of growth in your mouth? ❑ Yes ❑ No
Do you have any loose teeth? ❑ Yes ❑ No
Do you still have wisdom teeth? ❑ Yes ❑ No
Would You Like Fresher Breath? ❑ Yes ❑ No
Whiter Teeth? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No

If not,what would you change?_____
_____
_____
_____

Authorization and Release:

I have read the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor:

_____

Date:

_____

OFFICE USE ONLY

I verbally reviewed the Medical / Dental Infomation with the patient named herein.

Initials:_____ Date:_____

Doctor's Commets:_____
_____
_____
_____
_____
_____