Jagruti Patel D.D.S.

12750 Carmel Country Rd.,
Suite 114,
San Diego CA 92130

ABOUT YOU

Today's Date : _____

E-Mail Address : _____

Name: _____

I prefer to be called : _____ ☐ Male ☐ Female

Birthdate : ____/ ____/ _____ Age: _____ SS#: _____

Home Address : _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm # : (_____)_____ Pager / Cell # : _____

Wk # : (_____)_____ Ext: _____ DL # : _____

Employer : _____

Employee's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

☐ Previous ☐ Present Dentist : _____

Last Visit Date: _____

SPOUSE INFORMATION

His / Her Name : _____

Employer: _____

Wk # : (_____)_____ Ext: _____ DL # : _____

Birthdate : ____/ ____/ ____ Age: _____ SS#: _____

Person Responsible for Account : _____

Wk # : (_____)_____Ext: _____ Hm # : (_____)_____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Add: _____

Insurance Co. Phone: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ _____ Insured's ID: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Add: _____

Insurance Co. Phone: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ _____ Insured's ID: _____

Insured's Employer: _____

Employer's Address: _____

Neighbour Relative not living with you.

His / Her Name : _____ Relation: _____

Wk # : (_____)_____ Hm # : (_____)_____

Address : _____

_____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone: (_____)_____ Date of last visit: _____

Are You currently under the care of physician? ☐ Yes ☐ No

Please Explain: _____

MEDICAL HISTORY CONTINUED

Your current physical health is : ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over the counter or herbal supplemental 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

For Women:

Are you using prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

- ☐ Abnormal Bleeding
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones / Joints / Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Hear Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blister
- ☐ High Blood Pressure
- ☐ HIV^{+} / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problem
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis / Paget's Disease
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problem
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

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

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

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

_____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experience pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristle? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No if yes, why? _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment in due in full at the time of treatment

unless prior arrangements have been approved.

If this office accepts insurance, 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 here by authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost 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 Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

_____

Doctor's Signature Date