Sacramento Valley
DENTAL SPECIALISTS
• ORAL SURGERY • ENDODONTICS • PERIODONTICS

Patient Information

Date:

Personal Information

Full Name: _____ **Male** **Female**
Last *First* *Sex (Please Circle)*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Mobile Phone: _____

Email _____

SSN: _____ Driver's License Number: _____

Birth Date: _____ Marital Status (*Please Circle)*: **Married** **Single** **Child**

Employer: _____

Is patient a minor? Yes / No Name of Responsible Party: _____ Relationship**:** _____

Emergency Contact/ Relationship: _____ Emergency Phone Number: _____

Dental Insurance Information

	Primary Insurance		**Secondary Insurance**
Carrier Name:		Carrier Name:	
Carrier Phone:		Carrier Phone:	
Subscriber Name:		Subscriber Name:	
Subscriber ID/Social:		Subscriber ID/Social::	
Subscriber DOB:		Subscriber DOB:	

Medical Insurance Information

Carrier Name: _____ Subscriber Name: _____

Carrier Phone Number: _____ Subscriber ID/Social: _____

Group Plan Name: _____ Subscriber DOB: _____

Group Number: _____ Relationship to Patient: _____

Health Information

NAME:_____

I. Circle appropriate answer (*Leave blank if you do not understand the question)*

1. Yes / No Are you in pain now?
   If YES, explain_____
2. Yes / No Is your general health good?
   If NO, explain_____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain_____
4. Yes / No Are you being treated by a physician now?
   If YES, explain_____
   Date of last medical exam?_____ Reason for exam_____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain_____
   Date of last exam_____Name of treating dentist_____
6. Yes / No Has there been a change in your health within the last year?
   If Yes, explain_____

II. Have you experienced any of the following? (*Please circle Yes or No for each)*

Yes / No Chest pain	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night Sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

III. Have you had or do you have any of the following? (*Please circle Yes or No for each)*

Yes / No Heart Disease	Yes / No Cosmetic surgery	Yes / No Eating disorder
Yes / No Family history of heart	Yes / No Surgeries	Yes / No Osteoporosis
disease	Yes / No Hospitalization	Yes / No Thyroid Disease
Yes / No Heart attack	Yes / No Diabetes	Yes / No Asthma
Yes / No Artificial joint	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Stomach problems or ulcers	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart defects	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Heart murmurs	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Rheumatic fever	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Skin disease	Yes / No Emphysema or other lung	Yes / No Liver disease
Yes / No Hardening of arteries	disease	Yes / No Eye disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Transplants
Yes / No Seizures	Yes / No Stroke	Yes / No Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (*Please circle Yes or No for each)*

Yes / No Aspirin	Yes / No Valium	Yes / No Vicodin
Yes / No Darvon	Yes / No Demerol	Yes / No Percodan
Yes / No Codeine	Yes / No Penicillin	Yes / No Nitrous oxide
Yes / No Latex	Yes / No Food	Yes / No Metal
Yes / No Local anesthetic	Yes / No Erythromycin	OTHER:_____
(Novocain or Xylocaine)	Yes / No Tetracycline	

V. Are you taking or have you taken any of the following in the last three months? (*Please circle Yes or No for each)*

Yes / No	Bisphosphonate (Fosamax)	Yes / No	Tobacco in any form	Yes / No	Supplements
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Aspirin
Yes / No	Weight loss medications	Yes / No	Recreational drugs		
Yes / No	Corticosteroids	Yes / No	Antibiotics		

Please list all medications you are currently taking_____

VI. Women only (*Please circle Yes or No for each)*

Yes / No Are you or could you be pregnant? If YES, what month?_____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. All patients (*Please circle Yes or No for each)*

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, explain_____

_____

Yes / No Have you ever been pre-medicated for dental treatment?

If YES, explain_____

Yes / No Have you ever taken Fen-Phen?

If YES, when_____

Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the doctor of any change in my health and/or medication. Further, I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

HIPAA Information:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct and indirect treatment by other health care providers involved in my treatment); obtaining payment form third party payers (e.g. my insurance company); the day-to-day health care operations of your practice. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, any use or disclose that occurred prior to the date I revoke this consent is not affected.

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

Signature of Patient, Parent or Guardian	*Date*