# LOS GATOS DENTAL GROUP

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WELCOME TO OUR PRACTICE!

## ABOUT YOU

Today's Date: _____ E-mail Address:_____

**Name**:_____ I prefer to be called:_____
Last First Mi Mr Mrs Ms Dr

I prefer appointment reminders by (please circle all that apply): Email Text Phone

Birthdate: ____/____/____ Age:_____ Social Security #:_____ Driver License #: _____

Gender: Male Female Status: Single Married Divorced Widowed Separated

**Home Address**:_____
Street City State Zip
Home Phone #: (____)_____ Cell #:(____)_____ Work Phone(____)_____ Ext:_____
Where & When are best times to reach you?_____
Whom may we thank for referring you?_____
Other Family members seen by us: _____

**Employer**:_____ How long there?_____ Occupation:_____
Employer's Address _____
Street/PO box City State Zip

**Person Responsible for account if other than yourself**

Name:_____ Relation:_____ Home Phone:(____)_____ Social Security#:_____
Employer:_____ Work Phone:(___)_____ Ext:_____ Drivers License #:_____
Billing Address:_____
Street City State Zip

## SPOUSE INFORMATION

His/Her Name:_____ Birth date:____/____/____ Social Security #:_____
Employer:_____ Work Phone:(___)_____ Ext:_____ Drivers License #:_____

## DENTAL INSURANCE INFORMATION

Primary Dental Insurance
Insurance Company Name_____ Phone #:(____)_____ Group/ Policy #:_____
Insurance Company Address: _____
Street/PO box City State Zip
Insured's Name:_____ Insured's Social Security #:_____
Insured's Birth Date____/____/____ Relation:_____ Insured's Employer:_____
Employer's Address: _____
Street/PO box City State Zip

Secondary Dental Insurance
Insurance Company Name:_____ Phone #:(____)_____Group/ Policy #:_____
Insurance Company Address: _____
Street/PO box City State Zip
Insured's Name:_____ Insured's Social Security #:_____
Insured's Birth Date____/____/____ Relation:_____ Insured's Employer:_____
Employer's Address: _____
Street/PO box City State Zip

## MEDICAL INSURANCE INFORMATION

Insurance Company Name: _____Phone #: (_____)_____ Policy #:_____
Insurance Company Address: _____
Street/PO box City State Zip
Insured's Name:_____ Policy #/Medical Record # _____
Insured's Birth Date____/____/____ Relation:_____ Insured's Social Security #:_____
Insured's Employer:_____
Employer's Address: _____
Street/PO box City State Zip

Physicians Name:_____Date of last visit:_____
Address: _____Phone #: (_____)_____
Street City State Zip

Specialists Name (if applicable): _____Date of last visit:_____
Address: _____ Phone #: (_____)_____
Street City State Zip

## MEDICAL HISTORY

**Circle appropriate answer:**

Yes / No Is your current health good?
If No, please explain:_____
Yes / No Has there been a change in your health within the last year?
If Yes, please explain: _____
Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
If Yes, please explain: _____
Yes / No Are you currently under the care of a physician?
If Yes please explain: _____
Date of last medical exam? _____ Reason for exam? _____
Yes / No Have you ever been hospitalized or had a major operation?
If Yes, please explain: _____
Yes / No Have you ever been pre-medicated for dental treatment? If yes, Why? _____
Yes / No Are you on a special diet? Please explain: _____
Yes / No Have you ever been diagnosed with Sleep Apnea? When & what level? _____
Yes / No Have you ever had an overnight sleep study? When? _____
Yes / No Do you wake up in the morning with headaches? How often? _____
Yes / No Have you been told that you gasp for air or suddenly stop breathing while sleeping?
Yes / No Do you snore?
Yes / No Do you or have you used a CPAP? How frequently used?_____
Yes / No Are you taking any medications, pills, or drugs?
Please list all medication: _____
_____

**Are you Allergic to or have you had a Reaction to any of the following? (Circle Yes or No for each)**

| | | |
|---|---|---|
| Yes / No Aspirin | Yes / No Erythromycin | Yes / No Penicillin |
| Yes / No Codeine | Yes / No Latex | Yes / No Percodan |
| Yes / No Darvon | Yes / No Local Anesthetic | Yes / No Tetracycline |
| Yes / No Demerol | Yes / No Metal | Yes / No Valium |
| Yes / No Food | Yes / No Nitrous oxide | Yes / No Vicodin |

Other Allergies or Reactions: _____

# MEDICAL HISTORY CONTINUED

**Are you taking or have you taken any of the following in the last 3 months? (Circle yes or no for each)**

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Alcohol | Yes / No | Controlled substance | Yes / No | Recreational drugs |
| Yes / No | Antibiotics | Yes / No | Corticosteroids | Yes / No | Supplements |
| Yes / No | Aspirin | Yes / No | Osteoporosis medication | Yes / No | Tobacco in any form |
| Yes / No | Bisphosphonate (Fosomax) | Yes / No | Over-the-counter medications | Yes / No | Weight loss medications |

**For Women Only (Circle Yes or No for each)**

Yes / No Are you pregnant/Trying to get pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

**Have you experienced any of the following? (Circle yes or No for each)**

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | Bleeding problems | Yes / No | Easily winded | Yes / No | Joint pain or stiffness |
| Yes / No | Blood in stools | Yes / No | Eating disorders | Yes / No | Kidney problem |
| Yes / No | Blood in urine | Yes / No | Excessive bleeding | Yes / No | Night sweats |
| Yes / No | Blurred vision | Yes / No | Excessive thirst | Yes / No | Pain in jaw joints |
| Yes / No | Bruise easily | Yes / No | Fainting spells | Yes / No | Persistent cough |
| Yes / No | Chest pain | Yes / No | Fever | Yes / No | Recent significant weight loss |
| Yes / No | Convulsions | Yes / No | Frequent diarrhea | Yes / No | Ringing in ears |
| Yes / No | Coughing up blood | Yes / No | Frequent headaches | Yes / No | Shortness of breath |
| Yes / No | Diarrhea or constipation | Yes / No | Frequent urination | Yes / No | Sinus problems |
| Yes / No | Difficulty swallowing | Yes / No | Frequent vomiting | Yes / No | Stomach problems |
| Yes / No | Difficulty urinating | Yes / No | Hay fever | Yes / No | Swelling of limbs |
| Yes / No | Dizziness | Yes / No | Hives or rash | Yes / No | Swollen ankles |
| Yes / No | Dry mouth | Yes / No | Jaundice | | |

**Have you had or do you have any of the following? (Circle Yes or No for each)**

| | | | | | |
|---|---|---|---|---|---|
| Yes / No | AIDS/HIV Positive | Yes / No | Glaucoma | Yes / No | Psychiatric Care |
| Yes / No | Alzheimer's Disease | Yes / No | Heart Attack/Failure | Yes / No | Radiation Treatments |
| Yes / No | Anaphylaxis | Yes / No | Heart Murmur | Yes / No | Renal Dialysis |
| Yes / No | Anemia | Yes / No | Heart Pace Maker | Yes / No | Rheumatic Fever |
| Yes / No | Angina | Yes / No | Heart Trouble/Disease | Yes / No | Rheumatism |
| Yes / No | Arthritis/Gout | Yes / No | Hemophilia | Yes / No | Scarlet Fever |
| Yes / No | Artificial Heart Valve | Yes / No | Hepatitis A | Yes / No | Seasonal Allergies |
| Yes / No | Artificial Joint | Yes / No | Hepatitis B or C | Yes / No | Shingles |
| Yes / No | Asthma | Yes / No | Herpes | Yes / No | Sickle Cell Disease |
| Yes / No | Blood Disease | Yes / No | High Blood Pressure | Yes / No | Sinusitis |
| Yes / No | Blood Transfusion | Yes / No | Hypoglycemia | Yes / No | Spina Bifida |
| Yes / No | Cancer | Yes / No | Irregular Heartbeat | Yes / No | Stomach/Intestinal Disease |
| Yes / No | Chemotherapy | Yes / No | Leukemia | Yes / No | Stroke |
| Yes / No | Cold Sores/Fever Blisters | Yes / No | Liver Disease | Yes / No | Thyroid Disease |
| Yes / No | Congenital Heart Disorder | Yes / No | Low Blood Pressure | Yes / No | Tonsillitis |
| Yes / No | Diabetes | Yes / No | Lung Disease | Yes / No | Tuberculosis |
| Yes / No | Drug Addiction | Yes / No | Migraine headaches | Yes / No | Tumors or Growths |
| Yes / No | Emphysema | Yes / No | Mitral Valve Prolapse | Yes / No | Ulcers |
| Yes / No | Epilepsy or Seizures | Yes / No | Parathyroid Disease | Yes / No | Venereal Disease |

Yes / No Have you ever had any serious illness not listed above?
Comments: _____

# DENTAL HISTORY

Why have you come to the Dentist today?_____

| | | | |
|---|---|---|---|
| Yes/No | Are you currently in pain? | Yes/No | Do you floss daily? |
| Yes/No | Do you require antibiotics before dental treatment? | Yes/No | Do you brush daily? |
| Yes/No | Do you still have your wisdom teeth? | Yes/No | Do your gums ever bleed? |
| Yes/No | Have you ever had periodontal disease? | Yes/No | Would you like fresher breath? |
| Yes/No | Do you have looseness of your teeth? | Yes/No | Would you like whiter teeth? |

How healthy would you like to get your mouth?

A. Best it can be B. Average C. Don't really care

Should you need treatment, at what point should we address it?

A. When something isn't ideal B. When something is worsening C. When my tooth hurts or breaks.

What quality of dentistry do you want us to recommend?

A. Ideal, the best B. Average C. Just patch it

Your current dental health is: GOOD FAIR POOR

Yes/No Are you happy with your smile?
If No, what would you change?_____

Yes/No Have you experienced problems with any previous dental work?
If Yes, please expain?_____

Yes/No Are your teeth sensitive to heat, cold, or anything else?
If Yes, please explain? _____

Yes/No Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?
If Yes, please explain? _____

Yes/No Do you use anything additional to your brush and floss?
If Yes, what?_____
Do you use a manual or electric toothbrush? _____
Type of bristles on your toothbrush? HARD MEDIUM SOFT
How long do you use a toothbrush before replacing it? _____

Previous dentist:_____ Number: _____
Last visit date _____ Reason:_____

Why did you leave your previous dentist?_____
What did you like most & least about any dentist you have ever seen?_____

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I, _____affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I am aware and give my consent that Los Gatos Dental Group may need to contact my physician and any specialists necessary to discuss my medical and dental conditions and recommendations.
I am aware that this office requires 48 business hours notice to cancel or change an appointment, otherwise a per hour charge will be incurred. I am aware that payment is due at the time of service and any outstanding balance will be subject to finance charges. I have been given the opportunity to review and request copies of the Dental Materials Fact Sheet and the Notice of Privacy Practices. I certify that I am covered by _____ Insurance Company and I assign directly to Los Gatos Dental Group, all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of all services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient Signature _____ Date_____

Responsible Party Signature_____ Date _____

Treating Dentist Signature _____ Date _____