Davidson Dental

443 Joaquin Ave., San Leandro, CA 94577 • 510.352.9212 • Fax 510.352.4313

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have any questions we'll be glad to help you. We look forward to serving your comprehensive family dental health needs.

Patient Information

Date ____________ Home Phone ____________ Cell Phone ____________

Name ______________________________ Soc. Sec. # ____________
Last Name First Name Initial

Email Address ____________ Street Address ____________

City ____________ State ____________ Zip ____________

Sex ☐ M ☐ F Age ______ Birth Date ____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by ____________ Occupation ____________

Business Address ____________ Business Phone ____________

Whom may we thank for referring you? ____________

In case of emergency who should be notified? ____________ Phone ____________

Primary Insurance

Person Responsible for Account ______________________________
Last Name First Name Initial

Relationship to Patient ____________ Birth Date ____________ Soc. Sec. # ____________

Address (if different from patient's) ____________ Phone ____________

City ____________ State ____________ Zip ____________

Person Responsible Employed by ____________ Occupation ____________

Patient Employed by ____________ Occupation ____________

Business Address ____________ Business Phone ____________

Insurance Company ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Names of other dependents covered under this plan ____________

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ____________ Relation to Patient ________ Birth Date ____________

Address (if different from patient's) ____________ Phone ____________

City ____________ State ____________ Zip ____________

Subscriber Employed by ____________ Business Phone ____________

Insurance Company ____________ Soc. Sec. # ____________

Contract # ____________ Group # ____________ Subscriber # ____________

Names of other dependents covered under this plan ____________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with____

Name of insurance Company(ies)

and assign directly to Dr. ______________________ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Most insurance companies do not pay for composite resin on posterior teeth. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my submissions whether manual or electronic.

__________________________ ____

Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of ______________________________________ do hereby request

Name of minor child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

__________________________ ____

Date *Signature of Insured Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

__________________________ ____

Date *Signature of Insured Guardian*

CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions during examination, the most common being root canal therapy, or crown during or following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(initials _______)

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For the following questions, please (x) whichever applies, your answers are for our records and will be kept confidential in accordance with applicable laws. Please note that during your initial exam, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know	
○	○	○	Do your gums bleed when you brush?
○	○	○	Are your teeth sensitive to cold, hot, sweets or pressure?
○	○	○	Have you had periodontal (gum) treatments?
○	○	○	Have you ever had orthodontic (braces) treatment?
○	○	○	Do you have headaches, earaches or neck pains?
○	○	○	Do you wear removable dental appliances?
○	○	○	Have you had serious/difficult problems associated with any previous dental treatment? If so, explain____________________________

____

How would you describe your current dental problem?______________________________________

Date of your last dental exam ______________________________Date of last dental x-rays ____________________

What was done at that time?____

How do you feel about the appearance of your teeth?______________________________________

Medical Information

Yes	No	Don't Know	
○	○	○	Are you in good health?
○	○	○	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: if you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Yes	No	Don't Know	
☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood

○ ○ ○ Are you now under the care of a physician? If so, what is/are the condition(s) being treated? ____________________

____ Date of last physical examination

Physician(s)

____
Name Phone Address City/State/Zip

____
Name Phone Address City/State/Zip

○ ○ ○ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what medicine(s) are you taking?

____

Prescribed ____

Over the counter____

Natural or herbal preparations ____

Are you taking, or have you taken, any diet drugs?_________________________________

Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? ________ In the past month? _________

If yes, ___________ # if drinks per day for_________# of years, ______________________________

○ ○ ○ Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ○ Yes ○ No

○ ○ ○ Do you use drugs or other substances for recreational purposes? If yes, please list:______________________________

○ ○ ○ Frequency of use (daily, weekly, etc.) ___________Number of years of recreational use: ______________________

○ ○ ○ Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping?
(Check one) ○ Very ○ Somewhat ○ Not Interested

○ ○ ○ Do you wear contact lenses? ____

Allergies: Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
○	○	○	Local anesthetics	○	○	○	Latex
○	○	○	Aspirin	○	○	○	Iodine
○	○	○	Penicillin or other antibiotics	○	○	○	Hay fever/seasonal
○	○	○	Barbiturates, sedatives, or sleeping pills	○	○	○	Animals
○	○	○	Sulfa drugs	○	○	○	Food (Specify)
○	○	○	Codeine or other narcotics	○	○	○	Other (Specify)

To yes responses, specify type of reaction ____ Please complete both sides

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Yes No Don't Know

(Women Only)

☐ ☐ ☐ Are you pregnant?

☐ ☐ ☐ Nursing?

☐ ☐ ☐ Taking birth control pills?

○ ○ ○ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? ___________

○ ○ ○ Have you had any complications or difficulties with your prosthetic joint? ___________

○ ○ ○ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

If so, what antibiotic and dose? ___________

____

Name of physician or dentist Phone

NOTE TO PATIENT: A new report (July 1997) prepared and endorsed by the American Dental Association and the American Academy of Orthopedic Surgeons has recommended that antibiotic prophylaxis before dental treatment is not indicated for most dental patients with orthopedic prosthetic joints. This office will be glad to discuss this report with you and provide a copy of it to you and your orthopedic surgeon/physician.

Please (X) if you have or had any of the following diseases or problems.

Yes No Don't Know

☐ ☐ ☐ Abnormal bleeding

☐ ☐ ☐ AIDS or HIV infection

☐ ☐ ☐ Anemia

☐ ☐ ☐ Arthritis

☐ ☐ ☐ Rheumatoid arthritis

☐ ☐ ☐ Asthma

☐ ☐ ☐ Blood transfusion

If yes, date _______

☐ ☐ ☐ Cancer/chemotherapy/ radiation treatment

☐ ☐ ☐ Cardiovascular disease

if yes, specify below

- ○ Angina
- ○ Arteriosclerosis
- ○ Artificial heart valves
- ○ Coronary insufficiency
- ○ Coronary occlusion
- ○ Damaged heart valves
- ○ Heart attack
- ○ Heart murmur
- ○ High blood pressure
- ○ Inborn heart defects
- ○ Mitral valve prolapse
- ○ Pacemaker
- ○ Rheumatic heart disease

☐ ☐ ☐ Chest pain upon exertion

☐ ☐ ☐ Chronic pain

☐ ☐ ☐ Persistent Diarrhea

Yes No Don't Know

☐ ☐ ☐ Disease, drug or radiation Induced immunosuppression

☐ ☐ ☐ Diabetes, if yes, specify below

- ○ Type I (Insulin dependent)
- ○ Type II Diabetes

☐ ☐ ☐ Dry mouth

☐ ☐ ☐ Eating disorder

if yes, specify ___________

☐ ☐ ☐ Epilepsy

☐ ☐ ☐ Fainting spells or seizures

☐ ☐ ☐ G.R. reflux

☐ ☐ ☐ Glaucoma

☐ ☐ ☐ Hemophilia

☐ ☐ ☐ Hepatitis, jaundice or liver disease

☐ ☐ ☐ Recurrent infections

indicate type of infection

____

☐ ☐ ☐ Kidney problems

☐ ☐ ☐ Low blood pressure

☐ ☐ ☐ Mental health disorders

If yes, specify below

____

____

☐ ☐ ☐ Malnutrition

☐ ☐ ☐ Migraines

☐ ☐ ☐ Night sweats

Yes No Don't Know

☐ ☐ ☐ Neurological disorders

If yes, specify ___________

☐ ☐ ☐ Osteoporosis

☐ ☐ ☐ Persistent swollen glands in neck

☐ ☐ ☐ Respiratory problems

If yes, specify below

- ○ Emphysema
- ○ Bronchitis, etc.

☐ ☐ ☐ Severe headaches

☐ ☐ ☐ Severe or rapid weight loss

☐ ☐ ☐ Sexually transmitted disease

☐ ☐ ☐ Sinus trouble

☐ ☐ ☐ Sleep disorder

☐ ☐ ☐ Sores or ulcers in the mouth

☐ ☐ ☐ Stroke

☐ ☐ ☐ Systemic lupus erythematosus

☐ ☐ ☐ Thyroid problems

☐ ☐ ☐ Tuberculosis

☐ ☐ ☐ Ulcers

☐ ☐ ☐ Excessive urination

☐ ☐ ☐ Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:

____

____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____

Signature of Patient or Legal Guardian Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist