



12750 Carmel Country Rd. #209
San Diego, CA 92130
(858) 755-7805

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

Preferred Name: _____ Male ___ Female ___

Birth date: _____ SSN: _____

Driver's License #: _____

Home address: _____

City _____ State _____ Zip _____

Hm # _____ Cell # _____

Wk # _____ Pgr # _____

Email _____

How do you prefer to confirm your appointments?
Circle One: WORK CELL HOME

Employer: _____

Occupation: _____

How did you hear about our office? _____

Whom may we thank for referring you? _____

Other family members seen by us?

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relation: _____

Wk # _____ Hm # _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Insured's ID: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Group # _____

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Insured's ID: _____

Financial Responsibility

Person accepting financial responsibility:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Birth date: _____ SSN: _____

Driver's License #: _____

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? Yes No

If yes, please list: _____

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

Have you or do you take Redux/Fen Phen or Pondimin? Yes No

For women: Are you taking birth control pills? 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?

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--------------------------------|-------------------|---|---|--------------------|---|---|-----------|---|---|--------|---|---|-----------|---|---|--------------------------------|---|---|--------|---|---|--------------------|---|---|---------------------|---|---|---------|---|---|-------------------------|---|---|----------|---|---|----------------------|---|---|--------------|---|---|-----------|---|---|----------|---|---|-----------------------|---|---|--------------------|---|---|----------|---|---|--------------|---|---|--------------|---|---|---------------|---|---|------------|---|---|---|-----------------------|---|---|---------------------|---|---|----------------|---|---|-----------|---|---|------------------|---|---|-----------------|---|---|---------------|---|---|---------------|---|---|--------------------|---|---|-----------------------|---|---|-----------------|---|---|-----------|---|---|----------------------|---|---|------------------|---|---|---------------------|---|---|-------------------------|---|---|----------|---|---|----------|---|---|-----------|---|---|--------|---|---|------------------|---|---|--------------|---|---|--------|
| <table border="0" style="width: 100%;"> <tr><td>Y</td><td>N</td><td>Abnormal Bleeding</td></tr> <tr><td>Y</td><td>N</td><td>Alcohol/Drug Abuse</td></tr> <tr><td>Y</td><td>N</td><td>Allergies</td></tr> <tr><td>Y</td><td>N</td><td>Anemia</td></tr> <tr><td>Y</td><td>N</td><td>Arthritis</td></tr> <tr><td>Y</td><td>N</td><td>Artificial Bones/Joints/Valves</td></tr> <tr><td>Y</td><td>N</td><td>Asthma</td></tr> <tr><td>Y</td><td>N</td><td>Blood Transfusions</td></tr> <tr><td>Y</td><td>N</td><td>Cancer/Chemotherapy</td></tr> <tr><td>Y</td><td>N</td><td>Colitis</td></tr> <tr><td>Y</td><td>N</td><td>Congenital Heart Defect</td></tr> <tr><td>Y</td><td>N</td><td>Diabetes</td></tr> <tr><td>Y</td><td>N</td><td>Difficulty Breathing</td></tr> <tr><td>Y</td><td>N</td><td>Ear Problems</td></tr> <tr><td>Y</td><td>N</td><td>Emphysema</td></tr> <tr><td>Y</td><td>N</td><td>Epilepsy</td></tr> <tr><td>Y</td><td>N</td><td>Fainting/Dizzy Spells</td></tr> <tr><td>Y</td><td>N</td><td>Frequent Headaches</td></tr> <tr><td>Y</td><td>N</td><td>Glaucoma</td></tr> <tr><td>Y</td><td>N</td><td>Heart Attack</td></tr> <tr><td>Y</td><td>N</td><td>Heart Murmur</td></tr> <tr><td>Y</td><td>N</td><td>Heart Surgery</td></tr> <tr><td>Y</td><td>N</td><td>Hemophilia</td></tr> </table> | Y | N | Abnormal Bleeding | Y | N | Alcohol/Drug Abuse | Y | N | Allergies | Y | N | Anemia | Y | N | Arthritis | Y | N | Artificial Bones/Joints/Valves | Y | N | Asthma | Y | N | Blood Transfusions | Y | N | Cancer/Chemotherapy | Y | N | Colitis | Y | N | Congenital Heart Defect | Y | N | Diabetes | Y | N | Difficulty Breathing | Y | N | Ear Problems | Y | N | Emphysema | Y | N | Epilepsy | Y | N | Fainting/Dizzy Spells | Y | N | Frequent Headaches | Y | N | Glaucoma | Y | N | Heart Attack | Y | N | Heart Murmur | Y | N | Heart Surgery | Y | N | Hemophilia | <table border="0" style="width: 100%;"> <tr><td>Y</td><td>N</td><td>Herpes/Fever Blisters</td></tr> <tr><td>Y</td><td>N</td><td>High Blood Pressure</td></tr> <tr><td>Y</td><td>N</td><td>Sinus Problems</td></tr> <tr><td>Y</td><td>N</td><td>HIV+/AIDS</td></tr> <tr><td>Y</td><td>N</td><td>Stomach Problems</td></tr> <tr><td>Y</td><td>N</td><td>Kidney Problems</td></tr> <tr><td>Y</td><td>N</td><td>Latex Allergy</td></tr> <tr><td>Y</td><td>N</td><td>Liver Disease</td></tr> <tr><td>Y</td><td>N</td><td>Low Blood Pressure</td></tr> <tr><td>Y</td><td>N</td><td>Mitral Valve Prolapse</td></tr> <tr><td>Y</td><td>N</td><td>Nervous/Anxious</td></tr> <tr><td>Y</td><td>N</td><td>Pacemaker</td></tr> <tr><td>Y</td><td>N</td><td>Psychiatric Problems</td></tr> <tr><td>Y</td><td>N</td><td>Venereal Disease</td></tr> <tr><td>Y</td><td>N</td><td>Radiation Treatment</td></tr> <tr><td>Y</td><td>N</td><td>Rheumatic/Scarlet Fever</td></tr> <tr><td>Y</td><td>N</td><td>Seizures</td></tr> <tr><td>Y</td><td>N</td><td>Shingles</td></tr> <tr><td>Y</td><td>N</td><td>Hepatitis</td></tr> <tr><td>Y</td><td>N</td><td>Stroke</td></tr> <tr><td>Y</td><td>N</td><td>Thyroid Problems</td></tr> <tr><td>Y</td><td>N</td><td>Tuberculosis</td></tr> <tr><td>Y</td><td>N</td><td>Ulcers</td></tr> </table> | Y | N | Herpes/Fever Blisters | Y | N | High Blood Pressure | Y | N | Sinus Problems | Y | N | HIV+/AIDS | Y | N | Stomach Problems | Y | N | Kidney Problems | Y | N | Latex Allergy | Y | N | Liver Disease | Y | N | Low Blood Pressure | Y | N | Mitral Valve Prolapse | Y | N | Nervous/Anxious | Y | N | Pacemaker | Y | N | Psychiatric Problems | Y | N | Venereal Disease | Y | N | Radiation Treatment | Y | N | Rheumatic/Scarlet Fever | Y | N | Seizures | Y | N | Shingles | Y | N | Hepatitis | Y | N | Stroke | Y | N | Thyroid Problems | Y | N | Tuberculosis | Y | N | Ulcers |
| Y | N | Abnormal Bleeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Alcohol/Drug Abuse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Allergies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Artificial Bones/Joints/Valves | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Asthma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Blood Transfusions | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Cancer/Chemotherapy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Colitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Congenital Heart Defect | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Difficulty Breathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Ear Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Epilepsy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Fainting/Dizzy Spells | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Frequent Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Glaucoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Heart Attack | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Heart Murmur | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Heart Surgery | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Hemophilia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Herpes/Fever Blisters | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | High Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Sinus Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | HIV+/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Stomach Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Kidney Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Latex Allergy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Liver Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Low Blood Pressure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Mitral Valve Prolapse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Nervous/Anxious | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Pacemaker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Psychiatric Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Venereal Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Radiation Treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Rheumatic/Scarlet Fever | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Shingles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Hepatitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Stroke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Thyroid Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Tuberculosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Ulcers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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

Are you allergic to any of the following items?

- | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--------------------|---------|---|---|---------|---|---|--------------------|---|---|--------------|--|---|---|-------|---|---|------------|---|---|--------------|---|---|-------|
| <table border="0" style="width: 100%;"> <tr><td>Y</td><td>N</td><td>Aspirin</td></tr> <tr><td>Y</td><td>N</td><td>Codeine</td></tr> <tr><td>Y</td><td>N</td><td>Dental Anesthetics</td></tr> <tr><td>Y</td><td>N</td><td>Erythromycin</td></tr> </table> | Y | N | Aspirin | Y | N | Codeine | Y | N | Dental Anesthetics | Y | N | Erythromycin | <table border="0" style="width: 100%;"> <tr><td>Y</td><td>N</td><td>Latex</td></tr> <tr><td>Y</td><td>N</td><td>Penicillin</td></tr> <tr><td>Y</td><td>N</td><td>Tetracycline</td></tr> <tr><td>Y</td><td>N</td><td>Other</td></tr> </table> | Y | N | Latex | Y | N | Penicillin | Y | N | Tetracycline | Y | N | Other |
| Y | N | Aspirin | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Codeine | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Dental Anesthetics | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Erythromycin | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Latex | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Penicillin | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Tetracycline | | | | | | | | | | | | | | | | | | | | | | | |
| Y | N | Other | | | | | | | | | | | | | | | | | | | | | | | |

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? Yes No

If Yes, please explain: _____

How would you describe the condition of your teeth and gums?
 Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums?
 Yes No If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? Yes No

Do your gums bleed when you floss? Yes No

Have you ever experienced pain in you jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

Do you grind or clench your teeth? Yes No

I understand that this information is correct to the best of my knowledge. I understand 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Signature _____ Date _____

Patient portion is due in full at the time of treatment.

Updated Medical History/Consent

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

R. Andres Garcia, DDS

12750 Carmel Country Rd. #209

San Diego, CA 92130

(858) 755-7805



What to expect...

We would like to welcome you to our practice, and look forward to providing you with quality dental care. Your initial visit will consist of a comprehensive oral examination, diagnosis, and prophylaxis. This will include necessary x-rays, periodontal evaluation, cancer screening, and a thorough clinical examination.

Appointments...

We are dedicated to respecting your time and reserve dedicated appointment times for your dental care. If you are unable to keep a scheduled appointment, we appreciate a 48 hour notice.

Your insurance...

If you have dental insurance, we are happy to help you receive the maximum allowable benefits. In order to achieve this, we ask your assistance and understanding. As a courtesy, we will assist you by billing your insurance. However, you are responsible for knowing your insurance benefits, including maximums, waiting periods, and frequency limitations.

If, for some reason, your insurance does not pay or respond within 45 working days, you will be responsible for the remaining portion. If your insurance company pays after the 45 days, we will be happy to reimburse you.

We ask you to keep in mind that, very commonly, your insurance will pay for the least expensive treatment possible in restoring dental health. For example, allowances are made for silver, mercury fillings on all back teeth, and composite (tooth-colored) restorations are not usually a covered benefit.

Of course, you and your dentist are free to choose any treatment option you feel is best, but understand that any expense not covered by your insurance is your responsibility. Your estimated share of cost is expected on the date services are rendered.

We look forward to working with you toward a lifetime of dental health.

I have read, understand, and agree to the above.

Signature _____ **Date** _____