

234 N. D Street ∙ San Bernardino, CA 92401 ∙ (909) 386-7878 ∙ (909) 386-7881 Fax

# NEW PATIENT INFORMATION

The following information is for our records ONLY: **PLEASE PRINT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A. | Patient Name |  | Birth date |  | | | | | | Age |  | |
| Address  City  Social Security #  Employed by  Employer Address  City  Occupation | |  | Apt. #: |  | | | Phone # | | | | |
|  | State |  | | | Zip Code | |  | | | |
|  | Email Address: | | |  | | | | | | |
|  | Work Phone # | | Cell # | | | | | | | |
|  | | | | | | | | | | |
|  | State |  | | | Zip Code | |  | | | |
|  | | | | | | How Long | | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **B.** | Responsible Party |  | | | Phone # |  | | | | | | | | | | | |
| Address  City  Social Security #  Employed by  Employer Address  City  Occupation | |  | | | Email Address: | | | |  | | | |  | | | | |
|  | | | State |  | | | Zip Code | | |  | | | | | |
|  | | | Drivers License #: | | | |  | | | | | | | | |
|  | | | Work Phone # | | Ext. | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | State |  | | | Zip Code | | |  | | | | | |
|  | | | | | | | | How Long | | | |  |  |  |
| Relationship to Patient | |  | Bill to which Address (circle one): | | | | | | | | **A** or **B** | | | | | | |
| Insurance Provider | |  | | Plan Name/Group# | | | |  | | | | | | | | | |

**HEALTH HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you now being treated or have been treated within the last year by a physician? Yes  No | | | | | | | | | | | | |
| If yes, please state name of physician | | | |  | | | | | | | | |
| Have you ever had surgery? Yes No | | | | | If yes, what type? | | |  | | | | |
| Are you currently taking any prescribed medication, drugs or pills? Yes  No | | | | | | | | | | | | |
| If yes, please list those drugs |  | | | | | | | | | | | |
| **Have you ever experienced a reaction to any of the following drugs? Please circle yes or no on all questions.** | | | | | | | | | | | | |
| Aspirin | | | Y | | | N | Sleeping Pills | | | Y | | N |
| Penicillin | | | Y | | | N | Dental Anesthetics (Novocain) | | | Y | | N |
| Codeine | | | Y | | | N |  | | |  | |  |
| **Have you ever had:** | |  | | | |  |  | |  | |  | |
| Heart Trouble | | | Y | | | N | Hepatitis (Liver Disease) | | | Y | | N |
| Heart Attack | | | Y | | | N | Diabetes (Sugar in Blood) | | | Y | | N |
| Heart Murmur | | | Y | | | N | Anemia | | | Y | | N |
| A Stroke | | | Y | | | N | Tuberculosis | | | Y | | N |
| High Blood Pressure | | | Y | | | N | **Venereal Disease:** | | |  | |  |
| Epilepsy | | | Y | | | N | Syphilis | | | Y | | N |
| Bleeding Problems | | | Y | | | N | HIV | | | Y | | N |
| Asthma | | | Y | | | N | Gonorrhea | | | Y | | N |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has anyone in your family had diabetes? | | Yes  No | If yes, who? | |  |
| Do you consider yourself a nervous person? | | Yes  No | Do you Smoke? Yes  No | | |
| **FOR WOMEN ONLY:** | Are you taking birth control pill? Yes  No | | | Are you pregnant at the present time? Yes  No | |

**PERMIT FOR OPERATION**

This is to verify that I, the undersigned, consent to the performing of whatever operation may be decided upon to be necessary or advisable, and the use of local or general anesthetic as indicated.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**NOTICE OF RESPONSIBILITY**

“I understand that I am personally responsible for the cost of my dental care and will notify this office of any changes in my eligibility for insurance coverage.”

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |