



20445 Pacifica Dr, Ste B, Cupertino, CA 95014 408-996-8595

**WELCOME**

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

**PATIENT INFORMATION**

Date \_\_\_\_\_ Patient's Name \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph# (\_\_\_\_) \_\_\_\_\_ Work Ph# (\_\_\_\_) \_\_\_\_\_ Cell Ph# (\_\_\_\_) \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Email \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Divorced  Child  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency who should be notified? \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle  
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Is patient covered by additional dental insurance?  Yes  No  
**If yes, please complete the following secondary insurance information.**  
Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Insured's Soc. Sec. # \_\_\_\_\_ Insured's Birthdate \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**DENTAL HISTORY**

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Are you currently under physicians care?  Yes  No If yes, why \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No

Taking birth control pills/Hormone Therapy  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> HIV/AIDS/ARC            | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain TMJ/TMD        | <input type="checkbox"/> Tobacco Habit    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy/Seizures    | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Radiation Treatment     |   |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory Disease     |   |
| <input type="checkbox"/> Circulatory Problems    |   | <input type="checkbox"/> Rheumatic Fever         |   |

**MEDICATIONS**

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION**

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist. I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Payment is due in full at time of treatment unless prior arrangements have been approved.*