STONY PLAZA DENTAL

Patient's name ---------- **Office** ----------

Age ---------- **Date** ---------- **Chart No.** ----------

DENTAL HISTORY

• Date of last dental visit ---------- • Date of last x-ray----------

• Do you have an appliance (bridge, partial, dentures)? ◯ **YES** ◯ **NO** *If yes, age of appliance:* ----------

• What would you like to discuss with the dentist today? ----------

MEDICAL HISTORY

(REQUIRED INFORMATION)

• Physician's Name ---------- • Telephone # ----------

• Are you in good health? ◯ **YES** ◯ **NO** *If no, please explain:* ----------

• Have you had any serious illnesses or operations? ◯ **YES** ◯ **NO** *If yes, please explain:* ----------

• Have you had a blood transfusion? ◯ **YES** ◯ **NO** • Have you taken weight loss medicine? (e.g. Fen-Phen) ◯ **YES** ◯ **NO**

• Do you: Smoke? ◯ **YES** ◯ **NO** Use recreational drugs? ◯ **YES** ◯ **NO** Use chewing tobacco? ◯ **YES** ◯ **NO**

• Have you had prolonged bleeding? ◯ **YES** ◯ **NO** *If yes, check all that apply* ◯ after an operation ◯ injury ◯ extractions

• Is there any family history of: ◯ Diabetes ◯ Heart murmur/problems ◯ Tumors? *check all that apply.*

WOMEN *check all that apply.* • Are you: ◯ Pregnant ◯ Nursing ◯ Taking birth control pills?

• Have you ever had any of the conditions listed below? *Check YES or NO for each.*

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV	☐	☐	Cancer	☐	☐	Fever Blisters	☐	☐	Kidney Disease	☐	☐	Scarlett Fever
☐	☐	Allergies	☐	☐	Chemical Dependency	☐	☐	Heart Bypass	☐	☐	Liver Problems	☐	☐	Sinus Trouble
☐	☐	Anemia	☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Angina	☐	☐	Cold Sores	☐	☐	Heart Problem	☐	☐	Lung Disease	☐	☐	Thyroid Problem
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Heart Surgery	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Artificial Joint	☐	☐	Dizzy Spells	☐	☐	Hepatitis	☐	☐	Nervous/Mental Disorder	☐	☐	Tuberculosis
☐	☐	Artificial Heart Valve	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Pacemaker	☐	☐	Ulcer
☐	☐	Asthma	☐	☐	Emotional Disorder	☐	☐	HIV Positive	☐	☐	Psychiatric Care			
☐	☐	Back Problem	☐	☐	Epilepsy	☐	☐	Immunosuppressed	☐	☐	Radiation Therapy			
☐	☐	Bleeding Disorder	☐	☐	Fainting	☐	☐	Jaundice	☐	☐	Rheumatic Fever			

• Have you ever had any condition/problem not listed above? ◯ **YES** ◯ **NO** *If yes, please explain:* ----------

• **MEDICATIONS:** Please list all medications you are taking.

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• **ALLERGIES:** Please list allergies to any medications.

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The above information is complete & accurate to the best of my knowledge. I will not hold my dentist or staff responsible for any omissions I have made in completing this form.

Patient Signature/Responsible Party if patient is a minor Date

Health history reviewed by ---------- DDS Date ----------

• **Please review your health history. If there are no changes, initial below today's date.**

Recall Date ----------	Recall Date ----------	Recall Date ----------	Recall Date ----------
Patient's signature ----------	Patient's signature ----------	Patient's signature ----------	Patient's signature ----------
Doctor's signature ----------	Doctor's signature ----------	Doctor's signature ----------	Doctor's signature ----------

CONFIDENTIAL PATIENT INFORMATION

Please print clearly & be as thorough as possible.

• PATIENT INFORMATION

Name ---------- Social Security# **(required)** ----------
Address ---------- City/State ---------- Zip ----------
Date of Birth ---------- Home Phone ( ) ---------- Cell Phone ( )----------
Employer Name ----------Work Phone ( )----------
E-mail Address: ----------

• RESPONSIBLE PARTY INFORMATION

(insurance carrier)

Name of insured---------- Social Security# **(required)** ----------
Name of Insurance Co ---------- Group # ----------
Address ---------- City/State ---------- Zip ----------
Date of Birth ---------- Home Phone ( ) ---------- Cell Phone ( )----------
Employer Name ----------Work Phone ( )----------

• SECONDARY INSURANCE INFORMATION

(complete this section if patient has dual coverage)

Name of insured---------- Social Security# **(required)** ----------
Name of Insurance Co ---------- Group # ----------
Address ---------- City/State ----------Zip ----------
Date of Birth ---------- Home Phone ( ) ---------- Cell Phone ( )----------
Employer Name ---------- Driver's License # ----------

• GETTING TO KNOW YOU

Do you belong to the UCB campus? ◯ **YES** ◯ **NO** If yes, are you: ◯ Staff ◯ Student ◯ Other ----------
How did you hear about us? ----------
Do you belong to the UCB campus? ◯ **YES** ◯ **NO** UCB student ID (required) ----------

• EMERGENCY CONTACT LIST

Name ---------- Phone Number ----------

• INSURANCE PATIENTS PLEASE SIGN BELOW FOR BILLING PURPOSES

I have reviewed the following treatment plan & fees. I agree to be responsible for all charges for dental services & materials not paid by my insurance plan, unless the treating dentist or dental elective has a contractual agreement with my plan prohibiting all or a portion of such charges to the extent permitted under applicable laws. I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named entity.

Signature ----------Phone ( ) ---------- Date ----------