Michael Felix L. De La Cruz, Jr., D.M.D.

General Dentistry

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(951) 486-9179

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The more you communicate to us, enables us to better care for you.

PATIENT INFORMATION

Date Today: ______________

Name: ____________ ____________ ______
Last First MI

I prefer to be called ______________ ☐Male ☐Female

Birthdate:____________ Age: ____ SS#: ____________

Home Address:______________________________
Apt./Condo #

____________ ______ ______
City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home Phone: (___)__________ Pager/Cell (___)________

Work Phone (___)_________ Ext.____ Other #:__________

Employer: ______________________________

Employer's Address: ______________________________

____________ ______ ______
City State Zip

Length of Employment: ______ Occupation: ____________

When are best times to reach you? ______ A.M. ______ P.M.

Whom may we Thank for referring you? ______________

Other family members seen by us: ______________

____

Previous/Present Dentist: ______________
(Please circle)

Last Visit Date: ______________

Spouse/Parent information:

His/Her name: ______________________________

Employer: ______________________________

Position: ______________ Social Security #__________

Work Phone: (___)________ Home Phone: (___)________

Person Responsible for Account:

Name: ______________________________

Employer: ______________ Driver's License #: ________

Work Phone: (____)__________ Home Phone: (____)_____

Relationship: ____________ Social Security #__________

Billing Address: ______________________________

PRIMARY INSURANCE **Dental Insurance? ☐Yes ☐No**

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone: (____)__________________________

Group Number (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ___________

Insured's Birthdate: __/__/___ Insured's SS#: ___________

Insured's Employer: ______________________________

Employer's Address: ______________________________

____________ ______ ______
City State Zip

SECONDARY INSURANCE **Dental Insurance? ☐Yes ☐No**

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone: (____)__________________________

Group Number (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ___________

Insured's Birthdate: __/__/___ Insured's SS#: ___________

Insured's Employer: ______________________________

Employer's Address: ______________________________

____________ ______ ______
City State Zip

In the event of an emergency, whom should we contact?

His/Her Name: ______________ Relation: ___________

Work Phone: (____)__________ Home Phone: (____)________

Thank you for filling out this form completely.
If you have any question at any time, please ask us.

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

Medical History

Do you have a personal physician? ☐Yes ☐ No

Physician's name: ____________________

Address: ____________________

____
City State Zip

Phone # ____________ Date of last visit: ____________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐Yes ☐ No

Please explain: ____________________

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

Have you ever had a blood transfusion? ☐Yes ☐ No

Have you been exposed to the AIDS Virus? ☐Yes ☐ No

Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ☐Yes ☐ No

Do you wear a cardiac pacemaker? ☐Yes ☐ No

Have you had heart surgery? ☐Yes ☐ No

What is your blood pressure (If known)? ____________

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sedatives
Y	N	Barbiturates	Y	N	Jewelry	Y	N	Sulfa Drugs
Y	N	Codeine	Y	N	Latex	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Penicillin	Y	N	Other

Please list additional drugs/substance that cause allergic reactions:

____

____

For Women: Are you taking birth control pills? ☐Yes ☐ No

Are you pregnant? ☐ Unsure ☐Yes ☐ No

If yes, what week #? ____________

Are you nursing? ☐Yes ☐ No

Are you taking any of the following?

Acetaminophen	☐Yes	☐ No	Blood Pressure Medication	☐Yes	☐ No	Recreational Drugs	☐Yes	☐ No
Antibiotics	☐Yes	☐ No	Cold Remedies	☐Yes	☐ No	Steroids/Cortisone	☐Yes	☐ No
Antihistamines	☐Yes	☐ No	Digitalis/Heat Medication	☐Yes	☐ No	Thyroid Medicine	☐Yes	☐ No
Aspirin	☐Yes	☐ No	Insulin/Diabetes Drugs	☐Yes	☐ No	Tranquilizers	☐Yes	☐ No
Blood Thinners	☐Yes	☐ No	Nitroglycerin	☐Yes	☐ No			

Are you taking any prescription/over-the-counter drugs not listed above? ☐Yes ☐ No

If yes, please list each one: ____________________

Y	N	Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker
Y	N	Alcohol Abuse	Y	N	Fever Blisters	Y	N	Persistent Cough
Y	N	Anemia	Y	N	Frequent Headaches	Y	N	Psychiatric Problems
Y	N	Arthritis	Y	N	Glaucoma	Y	N	Radiation Treatment
Y	N	Artificial Bones/Joints	Y	N	Hay Fever	Y	N	Rheumatic Fever
Y	N	Artificial Valves	Y	N	Heart Attack	Y	N	Scarlet Fever
Y	N	Asthma	Y	N	Heart Murmur	Y	N	Seizures
Y	N	Blood Transfusion	Y	N	Heart Surgery	Y	N	Severe Headache
Y	N	Cancer	Y	N	Hemophilia	Y	N	Shingles
Y	N	Chemotherapy	Y	N	Hepatitis	Y	N	Sickle Cell Disease
Y	N	Chicken Pox	Y	N	Herpes/Fever Blisters	Y	N	Sinus Problems
Y	N	Colitis	Y	N	High Blood Pressure	Y	N	Steroid Therapy
Y	N	Congenital Heart Defect	Y	N	HIV/AIDS	Y	N	Stroke
Y	N	Diabetes	Y	N	Hospitalized for Any Reason	Y	N	Thyroid Problem
Y	N	Difficulty Breathing	Y	N	Kidney Problems	Y	N	Tonsillitis
Y	N	Drug Abuse	Y	N	Liver Disease	Y	N	Tuberculosis (TB)
Y	N	Emphysema	Y	N	Low Blood Pressure	Y	N	Ulcers
Y	N	Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have experienced: ____________________

____

NAME: ______________________ Birth Date: ______________ Date Today: ______________

Dental History

Why have you come to the dentist today? ______________________

How long since you've been to a dentist? ______________________

When was your last set of full mouth x-rays (14 or more)? ______________________

Have you experienced problems associated with any previous dental work? ☐Yes ☐ No

Do you have frequent headaches? ☐Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐ No

Your current dental health is ☐Good ☐Fair ☐ Poor

Do you floss daily? ☐Yes ☐ No Brush daily? ☐Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? __________

Do you use anything in addition to your brush and floss? ☐Yes ☐No
If yes, what? ______________________

Do your gums ever bleed? ☐Yes ☐ No Itch? ☐Yes ☐ No

Have you ever had periodontal disease? ☐Yes ☐ No

Have you ever been treated for periodontal disease? ☐Yes ☐ No

Do you have mobility in your teeth? ☐Yes ☐ No

Do you grind your teeth? ☐Yes ☐ No

Have you ever had orthodontic treatment? ☐Yes ☐ No

Does food get caught between your teeth? ☐Yes ☐ No

What is your teeth sensitive to? (Ex: Heat, Cold, etc.) __________

Do you still have your wisdom teeth? ☐Yes ☐ No

Have you lost any teeth? ☐Yes ☐ No
If yes, why? ______________________

Do you require antibiotics before dental work? ☐Yes ☐ No

Are you happy with the way your smile looks? ☐Yes ☐ No
If not, what would you change? ______________________

Remarks

Is there any additional dental information we need to know before beginning treatment? ______________________

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

______________________ Signature ______________ Date

I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that there will be a charge for any appointment not cancelled 24 hours in advance.

______________________ Signature ______________ Date

OFFICE USE ONLY ◆ OFFICE USE ONLY ◆ OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _______ Date: _________

Doctor's Comments: ______________________

MEDICAL HISTORY UPDATE

I have read my medical history dated __________ and confirmed that it states past and present medical conditions.

Patient Comments:

______________ Patient's Signature ______ Date

______________ Doctor's Signature ______ Date

I have read my medical history dated __________ and confirmed that it states past and present medical conditions.

Patient Comments:

______________ Patient's Signature ______ Date

______________ Doctor's Signature ______ Date

I have read my medical history dated __________ and confirmed that it states past and present medical conditions.

Patient Comments:

______________ Patient's Signature ______ Date