My DENTIST and Orthodontist

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

NEW PATIENT INFORMATION

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

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

B.
Responsible Party _____ Phone # _____
Address _____ Email Address: _____
City _____ State _____ Zip Code _____
Social Security # _____ Drivers License #: _____
Employed by _____ Work Phone # _____ Ext. _____
Employer Address _____
City _____ State _____ Zip Code _____
Occupation _____ 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 _____