SAN MATEO DENTAL OFFICE

Drs. Paul & Fred Diercks

320 N San Mateo Dr, San Mateo, CA 94401
(650) 342-7401

WELCOME TO OUR PRACTICE!

ABOUT YOU

Today's Date: ________________ E-mail Address:____
Name:____ I prefer to be called:______________________
Last First Mi Mr Mrs Ms Dr
Birthdate: ____/____/____ Age:______ Social Security #:___________________ ☐ Male ☐ Female
☐ Single ☐Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:____
Street City State Zip
Home Phone #: (____)_______________ Cell #:(____)_______________ Work Phone(____)_______________ Ext:_________
Driver License #: _______________ Where & When are best times to reach you?______________________________________
Whom may we thank for referring you?____
Other Family members seen by us: ____

Employer:_________________________________ How long there?_______ Occupation:___________________________
Employer's Address ____
Street/PO box City State Zip

Neighbor or Relative Not Living With you

His/her Name:_________________ Relation:____________ Work Phone:(___)___________ Home Phone:(___)___________
Address:____
Street City State Zip

Person Responsible for account if other than yourself

Name:____________________ Relation:____________ Home Phone:(____)____________ Social Security#:_______________
Employer:____________________ Work Phone:(___)_____________ Ext:_______ Drivers License #:______________________
Billing Address:____
Street City State Zip

SPOUSE INFORMATION

His/Her Name:__________________________ Birth date:____/____/____ Social Security #:____________________________
Employer:_____________________ Work Phone:(___)___________ Ext:_____ Drivers License #:________________________

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company Name__________________________ Phone #:(____)_____________ Group/ Policy #:_________________
Insurance Company Address: ____
Street/PO box City State Zip
Insured's Name:_____________________________________ Insured's Social Security #:___________________________
Insured's Birth Date____/____/____ Relation:________________ Insured's Employer:_______________________________
Employer's Address: ____
Street/PO box City State Zip

Secondary Dental Insurance

Insurance Company Name:__________________________ Phone #:(____)_____________Group/ Policy #:_________________
Insurance Company Address: ____
Street/PO box City State Zip
Insured's Name:_____________________________________ Insured's Social Security #:___________________________

Insured's Birth Date____/____/____ Relation:________________ Insured's Employer:______________________________________
Employer's Address: ____
Street/PO box City State Zip

DENTAL HISTORY

Why have you come to the Dentist today?____

Are you currently in pain?	YES NO	Do you floss daily?	YES NO
Do you require antibiotics before dental treatment?	YES NO	Do you brush daily?	YES NO
Do you still have your wisdom teeth?	YES NO	Do your gums ever bleed?	YES NO
Would you like fresher breath?	YES NO	Have you ever had periodontal disease?	YES NO
Would you like whiter teeth?	YES NO	Do you have looseness of your teeth?	YES NO

How healthy would you like to get your mouth?
A. Best it can be B. Average C. Don't really care
Should you need treatment, at what point should we address it?
A. When something isn't ideal B. When something is worsening C. When my tooth hurts or breaks.
What quality of dentistry do you want us to recommend?
A. Ideal, the best B. Average C. Just patch it

Your current dental health is: GOOD FAIR POOR
Type of bristles on your toothbrush? HARD MEDIUM SOFT
How long do you use a toothbrush before replacing it? ______________________
Do you use anything additional to your brush and floss? YES NO
If yes, what?____
Are you happy with your smile? YES NO
If not, what would you change?____
Have you experienced problems associated with any previous dental work? YES NO
Are your teeth sensitive to heat, cold, or anything else? YES NO
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? YES NO
Previous dentist name & number:____
Last visit date & reason:_____________________________
Why did you leave your previous dentist?____
What did you like most & least about any dentist you have ever seen?____

MEDICAL HISTORY

Your current physical health is: GOOD FAIR POOR
Are you currently under the care of a physician? YES NO
Comments:____
Have you ever been hospitalized or had a major operation? YES NO
Comments:____
Have you ever had a serious head or neck injury YES NO
Comments:____
Are you taking any medications, pills, or drugs? YES NO
Please list all medications:____
Do you, or have you taken, Phen-Fen or Redux? YES NO
Are you on a special diet? YES NO
Do you smoke or use tobacco in any form? YES NO
Do you use controlled substances? YES NO

Have you ever been Diagnosed with Sleep Apnea? YES NO
Have you ever had an overnight sleep study? YES NO
Do you wake up in the morning with headaches? YES NO
Have you been told that you gasp for air or suddenly stop breathing while sleeping? YES NO
Do you snore? YES NO
Do you or have you used a CPAP? YES NO

For Women, are you: ☐Pregnant/trying to get pregnant? ☐Nursing? ☐Taking Oral Contraceptives?

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metals ☐Latex ☐Local Anesthetic ☐Other ☐None

Please list any additional drugs/materials that cause allergic reactions:____

Physicians Name:____ Date of last visit:________________

Address: Phone #: ( )

Street City State Zip

Do you have or have you had any of the following?

☐AIDS/HIV Positive	☐Chest Pains	☐Frequent Headaches	☐Irregular Heartbeat	☐Scarlet Fever
☐Alzheimer's Disease	☐Cold Sores/Fever Blisters	☐Genital Herpes	☐Kidney Problem	☐Shingles
☐Anaphylaxis	☐Congenital Heart Disorder	☐Glaucoma	☐Leukemia	☐Sickle Cell Disease
☐Anemia	☐Convulsions	☐Hay Fever	☐Liver Disease	☐Sinus Trouble
☐Angina	☐Cortisone Medicine	☐Heart Attack/Failure	☐Low Blood Pressure	☐Spina Bifida
☐Arthritis/Gout	☐Diabetes	☐Heart Murmur	☐Lung Disease	☐Stomach/Intestinal Disease
☐Artificial Heart Valve	☐Drug Addiction	☐Heart Pace Maker	☐Mitral Valve Prolapse	☐Stroke
☐Artificial Joint	☐Easily Winded	☐Heart Trouble/Disease	☐Pain in Jaw Joints	☐Swelling of Limbs
☐Asthma	☐Emphysema	☐Hemophilia	☐Parathyroid Disease	☐Thyroid Disease
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Psychiatric Care	☐Tonsillitis
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Radiation Treatments	☐Tuberculosis
☐Breathing problem	☐Excessive Thirst	☐Herpes	☐Recent Weight Loss	☐Tumors or Growths
☐Bruise Easily	☐Fainting Spells/Dizziness	☐High Blood Pressure	☐Renal Dialysis	☐Ulcers
☐Cancer	☐Frequent Cough	☐Hives or Rash	☐Rheumatic Fever	☐Venereal Disease
☐Chemotherapy	☐Frequent Diarrhea	☐Hypoglycemia	☐Rheumatism	☐Yellow Jaundice

Have you ever had any serious illness not listed above? YES NO

Comments: ____

I, ________________________________affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I am aware that this office requires 48 business hours notice to cancel or change an appointment, otherwise a per hour charge will be incurred. I am aware that payment is due at the time of service and any outstanding balance will be subject to finance charges. I have been given the opportunity to review and request copies of the Dental Materials Fact Sheet and the Notice of Privacy Practices. I certify that I am covered by ______________________________ Insurance Company and I assign directly to Dr. Diercks all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of all services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____ ______________________

Signature Date