

DENTAL HISTORY OF PATIENT

Patient's Full Name: _____ Date of Birth: _____

Please indicate your preferred spoken language _____

(We are required by law [CA Health and Safety Code AB800, Section 123147] to request this information)

Emergency Visit: Yes ____ No ____ 1st Visit to a Dentist Yes ____ No ____ Male ____ Female ____

Name of Former Dentist: _____ City: _____

Have any other family members been a patient of our office before? Yes ____ No ____

If yes, please provide their names: _____

Present dental problem as you see it (if any): _____

Has the patient had any past bad experiences ? Yes ____ No ____

If yes, please explain: _____

How did you hear of us? Television Newspaper Phonebook Internet Health Fair
 Other _____

Emergency Contact Name/Relationship: _____ Phone: _____

MEDICAL HISTORY

*The following answers are confidential and are for our records only.
Your accurate answers will assist us to render the best possible dental care. Thank you.*

Is the patient in good health? Yes ____ No ____ Explain: _____

Has there been any change in the patient's general health within the past year? Yes ____ No ____

The last physical examination was on: _____

Is the patient currently under the care of a physician? Yes ____ No ____

If yes, provide the condition being treated: _____

Physician's Name: _____ Phone: _____

Physician's Address: _____

Is the patient currently taking any drugs or medication? Yes ____ No ____

If yes, please list: _____

Has the patient been hospitalized or had a serious illness within the past 5 years? Yes ____ No ____

If yes, please explain: _____

Has the patient had abnormal bleeding with previous extractions, surgery or trauma? Yes ____ No ____

If yes, please explain: _____

Has the patient had surgery or x-ray treatment for a tumor, growth or other condition? Yes ____ No ____

If yes, please explain: _____

DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?

Rheumatic Fever	Yes	No	Diabetes	Yes	No	Short of Breath		
Rheumatic Heart Disease	Yes	No	Arthritis	Yes	No	after Mild Exercise	Yes	No
Congenital Heart Lesions	Yes	No	Stomach Ulcers	Yes	No	Hepatitis, Jaundice		
Cardiovascular Disease	Yes	No	Kidney Trouble	Yes	No	or Liver Disease	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No	Blood Disorder		
Allergies	Yes	No	Persistent Cough	Yes	No	such as Anemia	Yes	No
Sinus Trouble	Yes	No	Coughing of Blood	Yes	No	Other _____		
Asthma or Hay Fever	Yes	No	Autoimmune Disease	Yes	No	_____		
Hives or Skin Rash	Yes	No	Bruise Easily	Yes	No	_____		
Fainting Spells or Seizures	Yes	No	Premature Birth	Yes	No	_____		

IS THE PATIENT ROUTINELY TAKING ANY OF THE FOLLOWING MEDICATIONS?

Antibiotics or Sulfa Drugs	Yes	No	Ritalin	Yes	No	Other _____
Cortisone (Steroids)	Yes	No	Anticoagulants			_____
Tranquilizers	Yes	No	(Blood Thinners)	Yes	No	_____
Antihistamines	Yes	No	Digoxin			_____
Aspirin	Yes	No	or Drugs for Heart Trouble	Yes	No	_____
Insulin or Similar Drug	Yes	No				_____

HISTORY OF ALLERGIC REACTION IN THE PATIENT OR IMMEDIATE FAMILY

Latex	Yes	No	Aspirin	Yes	No	Other _____
Local Anesthetics	Yes	No	Penicillin			_____
Sulfa Drugs	Yes	No	or Other Antibiotics	Yes	No	_____
Barbiturates	Yes	No	Codeine			_____
Sedatives	Yes	No	or Other Narcotics	Yes	No	_____
Sleeping Pills	Yes	No				_____

Do the patient use or has used bisphosphonate? Yes ____ No ____

Does the patient have any medical condition not listed above? Yes ____ No ____

If yes, please explain: _____

Does the patient have any special needs? Yes ____ No ____

If yes, please explain: _____

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I consent to have Drs. Chiang, Morris, Murillo, Saisho and their Associates and staff perform diagnostic dental procedures including x-rays, teeth cleaning, oral examination and application of fluoride on teeth. I understand that before any further care is rendered, I will be so informed and consent obtained.

Signature of Parent / Legal Guardian

Printed Name of Parent / Legal Guardian

Date

Time

FOR DENTISTS ONLY

Patient Resume:

Hospitalizations:

Surgeries:

Medications:

Allergies:

Medical Alert:

A.S.A. I, II, III, IV

Medical Consults Requested

Signature of Dentist

Date

Time