DELGADO DENTAL GROUP

In order for us to better serve you, please fill in the following information completely

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

(Do you have another name you prefer to be called?: _____

Address City: _____ ZIP Phone: _____

E-Mail Address: _____Cell Phone: _____

Your Occupation: _____Employer: _____Phone: _____

Spouse Employer Phone: _____Employer: _____Phone: _____

If patient is in school, name of school: _____

Person Financially Responsible: _____ Relationship: _____

Social Security #: _____License #: _____

Previous Dentist Last Visit: _____

How did you find out about our office; whom may we thank for referring you? _____

Reason for appointment or concern about your smile: _____

_____

For patients with Dental Insurance

Insurance Carrier (Mr.) _____ (Mrs.) _____

Union Name or No. (Mr.) _____ (Mrs.) _____

I hereby authorize payment directly to Juan Delgado, D.D.S., of the group insurance benefits otherwise payable to me.

Signed: _____ Date: _____

My signature below is an acknowledgement that I have received a copy of the Dental Materials Fact Sheet and have also been given a copy of the Notice of Privacy Practices. This is not a contract, authorization, release, or consent form.

Signed: _____ Date: _____

I. CIRCLE APPROPRIATE ANSWER *(leave blank if you do not understand the question)*:

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the past year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam: _____ Date of last dental appt. _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Weight Gain?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in the ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32 Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No TB, emphysema, other lung disease?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS or ARC?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No STD
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medicines (incl. aspirin)?
    Please list: _____
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills? VII. ALL

PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
    If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patients signature _____ Date _____

I hereby give permission to the Delgado Dental Group and/or the doctor in charge, to administer any treatment or to administer such anesthetics, and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of the patient named herein.

Signed _____ **Relationship** _____

Reviewed by Doctor _____