16918 Dove Canyon Rd, Suite 209
San Diego, CA 92127-3457
858-798-9595 (phone)
RadiantSmilesOfSD@yahoo.com
www.RadiantSmilesOfSD.com

# Welcome to Our Practice!

| Patient Information | Dental Insurance |
|---|---|
| Name | Policy Holder |
| Address | Relationship to Patient |
| City | Primary Insurance Co. |
| State Zip | Policy Holder SS# |
| E-mail | Birthdate |
| Sex ☐ M ☐ F | Secondary insurance? ☐ Y ☐ N |
| Birthdate | Policy Holder |
| Social Security # | Insurance Co. |
| Occupation | Policy Holder SS# |
| Employer/School | Birthdate |
| Employer/School Address | *I hereby authorize payment of benefits directly to the provider and release of all necessary information to the insurance carrier. I understand that I am financially responsible for all charges whether or not paid by insurance.* |
| Employer/School Phone ( ) | |
| How did you hear about our office? | **Signature of Insured** **Date** |

☐ Internet ☐ Mail ☐ Family/Friends ☐ Other:

## Phone Numbers

Home ( ) _____ Work ( ) _____ Mobile ( ) _____

☐ **Check box** if you would like to receive text reminders of your appointment *(charges may apply)*

**IN CASE OF EMERGENCY, CONTACT**
Name Phone

## Dental History

| | | | |
|---|---|---|---|
| Reason for today's visit | | | |
| Date of last dental visit | | Last full mouth x-rays | |
| Previous dentist's name | | | |
| **Mark "yes" or "no to indicate if you have or had any of the following:** | | | |
| Bad breath or bad taste | ☐ Y ☐ N | Jaw pain or tiredness | ☐ Y ☐ N |
| Bleeding gums | ☐ Y ☐ N | Loose teeth or broken fillings | ☐ Y ☐ N |
| Cigarette/cigar smoking | ☐ Y ☐ N | Mouth breathing | ☐ Y ☐ N |
| Clicking or popping jaw | ☐ Y ☐ N | Oral surgery | ☐ Y ☐ N |
| Difficulty with chewing | ☐ Y ☐ N | Orthodontic treatment | ☐ Y ☐ N |
| Food stuck between teeth | ☐ Y ☐ N | Sensitivity to cold/heat | ☐ Y ☐ N |
| Grinding/clenching teeth | ☐ Y ☐ N | Sensitivity to sweets | ☐ Y ☐ N |
| Gum surgery | ☐ Y ☐ N | Sensitivity when biting | ☐ Y ☐ N |

| Health History | | | |
|---|---|---|---|
| Physician's Name | | Phone | |
| **Mark "yes" or "no to indicate if you have or had any of the following:** | | | |
| AIDS/HIV | □ Y □ N | Headaches | □ Y □ N |
| Anemia | □ Y □ N | Heart attack | □ Y □ N |
| Arthritis/joint pain | □ Y □ N | Heart problems | □ Y □ N |
| Artificial heart valve | □ Y □ N | High blood pressure | □ Y □ N |
| Artificial joints | □ Y □ N | Kidney disease | □ Y □ N |
| Asthma | □ Y □ N | Liver disease | □ Y □ N |
| Bleeding abnormally with extractions or surgery | □ Y □ N | Psychiatric care | □ Y □ N |
| Bruising easily | □ Y □ N | Rheumatic fever | □ Y □ N |
| Cancer | □ Y □ N | Sexually transmitted disease | □ Y □ N |
| Canker / cold sores | □ Y □ N | Shortness of breath | □ Y □ N |
| Cosmetic surgery | □ Y □ N | Sinus trouble | □ Y □ N |
| Cough, persistent or bloody | □ Y □ N | Stroke | □ Y □ N |
| Diabetes | □ Y □ N | Swollen feet or ankles | □ Y □ N |
| Difficulty with swallowing | □ Y □ N | Thyroid problems | □ Y □ N |
| Eating disorder | □ Y □ N | Tuberculosis | □ Y □ N |
| Emphysema | □ Y □ N | Used bisphosphonates? | □ Y □ N |
| Epilepsy/seizures | □ Y □ N | Used "fen-phen"? | □ Y □ N |
| Fainting or dizziness | □ Y □ N | Weight loss, unexplained | □ Y □ N |
| **Women** | | | |
| Are you or could you be pregnant? | □ Y □ N | Due date: | |
| Are you nursing? | □ Y □ N | Are you taking birth control pills? | □ Y □ N |
| **Medications** | | | |
| List any prescription or over-the-counter medications you are taking: | | | |
| | | | |
| Pharmacy Name | | Phone | |
| Do you have any allergies to medications including local anesthetics? □ Y □ N<br>Please list: | | | |
| Are you allergic to latex? | □ Y □ N | | |
| *I certify that I have read and understand this form. 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. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. Further, if my dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to starting dental treatment. I authorize my dentist to contact my physician.* | | | |
| | | | |
| **Signature of Patient (Parent or Guardian)** | | **Date** | |
| | | | |
| **Signature of Dentist** | | **Date** | |

Rev. 11/2012