PATIENT INFORMATION

To help us render the proper dental services to you, please answer the following questions.

PLEASE PRINT

PATIENT _____ (FIRST NAME) _____ (LAST NAME)
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Birthdate ____/____/____ Driver's License # _____
Sex ❑ M / ❑ F Social Security # _____ - _____ - _____
What would you like us to call you? _____
Cell Phone (___) _____ Wk. Phone (___) _____
Hm. Phone (___) _____
Email _____
Employer _____
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Marital Status ❑ M / ❑ S / ❑ D / ❑ W / ❑ Sep

Whom should we call to confirm appointments? _____ Phone (___) _____

Whom should we call in case of emergency? _____ Phone (___) _____

Whom should we thank for referring you to us? _____ (FIRST NAME) _____ (LAST NAME)

Do you have any family members already in our practice? ❑ Yes ❑ No Who? _____

PERSON PAYING ACCOUNT _____ (FIRST NAME) _____ (LAST NAME)
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Birthdate ____/____/____ Driver's License # _____
Social Security # _____ - _____ - _____
Hm. Phone (___) _____ Wk. Phone (___) _____
Occupation _____ Length of Employment _____
Employer _____
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Place, time and number, during the day, to reach by phone _____

SPOUSE _____ (FIRST NAME) _____ (LAST NAME)
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Birthdate ____/____/____ Driver's License # _____
Social Security # _____ - _____ - _____
Hm. Phone (___) _____ Wk. Phone (___) _____
Occupation _____ Length of Employment _____
Employer _____
Address _____
City/State/Zip _____

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING

INS. COMPANY #1
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Phone (___) _____
Birthdate ____/____/____ Social Security # ____-____-____
Employee I.D. _____
Employee Name _____ (FIRST NAME) _____ (LAST NAME)
Employer Name _____
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Group # _____

INS. COMPANY #2
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Phone (___) _____
Birthdate ____/____/____ Social Security # ____-____-____
Employee Name _____ (FIRST NAME) _____ (LAST NAME)
Employer Name _____
Address _____
City/State/Zip _____ (CITY) _____ (STATE) _____ (ZIP)
Group # _____

Our office policy is to request payment of fees at the time of service, or to collect your portion if you have insurance. For your convenience we accept cash, check, or Visa/MasterCard. With credit approval we can provide an extended payment plan. Account balances over 90 days past due will be charged a 1-1/2% per month (18% per annum) finance charge. A charge of $20.00 will be made for all returned checks. We reserve the right to charge $50.00 for all missed appointments, or for cancellations with less than 24 hours notice.

I acknowledge full responsibility for the payment of services.
I authorize Livermore Dental Care to bill my insurance company(ies), and I authorize all insurance benefits to be paid directly to Livermore Dental Care.

Signature of responsible party: _____ Date: _____ Relation to Patient: _____ Doctor's Initials: _____

HEALTH / DENTAL HISTORY

What is your main reason for being here? ❑ Examination / ❑ Consultation / ❑ Emergency

Do you have a specific dental problem? ❑ Yes / ❑ No _____

Do you think you have active decay? ❑ Yes / ❑ No / ❑ Not Sure

Do your gums ever bleed? ❑ Yes / ❑ No / ❑ Sometimes

Do you feel nervous about having dental treatment? ❑ Yes / ❑ No

Have you had a bad experience in a dental office? ❑ Yes / ❑ No

Do you brux or grind your teeth? ❑ Yes / ❑ No / ❑ Sometimes

Have you had orthodontic treatment (braces)? ❑ Yes / ❑ No

Do you have clicking, popping, or pain in your jaw (TMJ)? ❑ Yes / ❑ No / ❑ Sometimes

Do you Smoke? ❑ Yes / ❑ No

Do you consume alcoholic beverages? ❑ Yes / ❑ No

Are you taking any medication, drugs, or pills? ❑ Yes / ❑ No Please list _____

Have you been hospitalized in the last 5 years? ❑ Yes / ❑ No Please explain _____

HAVE YOU EVER HAD THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Attack	❑	❑	Pacemaker	❑	❑	Mitral Valve Prolapse
❑	❑	Scarlet Fever	❑	❑	Hepatitis	❑	❑	Rheumatic Fever
❑	❑	Cancer	❑	❑	Chemotherapy	❑	❑	Kidney Problems
❑	❑	HIV / AIDS	❑	❑	Shingles	❑	❑	Radiation Treatment
❑	❑	Fever Blisters	❑	❑	Cold Sores	❑	❑	Artificial Joint
❑	❑	Stroke	❑	❑	Sinus Trouble	❑	❑	Artificial Valve
❑	❑	Diabetes	❑	❑	Tuberculosis	❑	❑	Psychiatric Problems
❑	❑	Ulcers	❑	❑	Colitis	❑	❑	Drug/Alcohol Depend
❑	❑	Anemia	❑	❑	Asthma	❑	❑	Hemophilia / Bleeding
❑	❑	Arthritis	❑	❑	Empyhsema	❑	❑	Venereal Disease
❑	❑	Fainting	❑	❑	Glaucoma	❑	❑	Diffculty Breathing
❑	❑	Heart Surgery	❑	❑	Blood Transfusion	❑	❑	High / Low Blood Pressure
			❑	❑	Bone loss drugs	❑	❑	Severe/Frequent Headaches

ARE YOU ALLERGIC TO OR HAVE HAD DIFFICULTY WITH:

Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Latex
❑	❑	Aspirin	❑	❑	Metals
❑	❑	Sulfa	❑	❑	Dental Anesthetic
❑	❑	Tetracycline	❑	❑	Phen-Phen
❑	❑	Codeine	❑	❑	Other drugs
❑	❑	Erythromycin			

Any other condition not listed: _____

Prosthetics or Implants: _____

Type: _____

PLEASE CHECK ONE IN EACH SECTION:

❑ My mouth is very comfortable.
❑ My mouth is sometimes uncomfortable.

❑ I think the appearance of my smile is excellent.
❑ I am satisfied with the appearance of my smile.
❑ I am unconcerned about the appearance.
❑ I would like to change my smile.

❑ I will do whatever I must to keep my teeth.
❑ I want to keep my teeth but only within a certain budget of time and money.

❑ I have always done what was recommended to me.
❑ I have not done what was recommended to me.
❑ I have not had dentistry recommended to me.

❑ I think my present state of dental health is excellent.
❑ I think my present state of health is good.
❑ I think my present state of health is poor.

FOR WOMEN ONLY:

Are you Pregnant? ❑ Yes / ❑ No
Are you Nursing? ❑ Yes / ❑ No
Are you taking Birth Control Pills? ❑ Yes / ❑ No

Signature of responsible party: _____ Date: _____ Relation to Patient: _____ Doctor's Initials: _____