A L B E R T O T A Y L O R D D S
7 9 1 B a y s i d e R o a d S u i t e 2
A r c a t a, C A 9 5 5 2 1
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WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Patient's Name _____ Social Security # _____-_____-_____

Address

_____

Home Phone _____ Cell Phone _____ Email

_____

Birth date _____ Sex ___ Male ___Female ___Single ___Married ___Widowed ___Separated ___Divorced

Patient Employed by_____

Occupation_____

If patient is a minor, give parent or guardian's name_____

Name of nearest relative not living with you

_____

INSURANCE INFORMATION

Person Responsible for Account _____ Relationship to Patient_____

_____

Business Address_____ Business Phone

_____

Business Email_____

Insured's Name _____ Bithdate_____ Insured Social Security #_____

Insurance Company _____ Group #_____Contract#_____

Insurance Co. Address _____

Phone_____

Name of other dependents under this plan

SECONDARY INSURANCE

Subscriber's Name _____ Relationship to Patient _____ Birthdate _____ Social Security#_____

Address (if different from patient)

_____

Home Phone _____ Cell Phone _____ Email

_____

Insurance Company _____ Group # _____ Contract #

_____

Insurance Co. Address _____ Phone

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.