The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Milpitas Dental Center

"We've got Milpitas Smiling"

About You

Today's Date: _____ E-mail Address: _____

Name:_____ I prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthday:___/___/___ Age:___ Social Security#:_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address:_____
Street City State Zip

Home Phone #: (___)_____ Cell#: (___)_____ Work Phone #: (___)_____Ext._____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/ PO Box City Zip

Neighbor or Relative not living with you

His/Her Name_____ Relation: _____ Work Phone #: (___)_____ Home Phone #: (_____)_____

Address: _____
Street City State Zip

Insurance Information

Primary Insurance:

Insurance Co. Name: _____ Phone #: (___)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthday: ___/___/___ Relation: _____

Insured's Employer: _____

Spouse Information

His/Her Name: _____ Birthday: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (___)_____ Ext: _____

Insurance Co. Name: _____ Phone #: (___)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zip

Person Responsible for account: _____

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No Brush Daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold or anything else? _____

Do you have mobility in your teeth? ☐ Yes ☐ No

Previous/ Present Dentist: _____ Last visit date: _____
(Please circle)

Why did you leave your last dentist? _____

Do you have or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD) ? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

If yes, what would you change? _____

Do you want to learn more about whitening? ☐ Yes ☐ No

Have you ever had any serious complications with prior dental treatment? ☐ Yes ☐ No

If yes, what? _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No

Week #: _____ Are you nursing? ☐ Yes ☐ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Congenital HeartDefect	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Artificial Bones/Joint	Y N Drug Abuse	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Vales	Y N Emphysema	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N HIV +/ AIDS	Y N Rheumatic	Y N Ulcers
Y N Chicken Pox	Y N Glaucoma		Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical conditions that you have experienced: _____

Are you taking any prescription/ over the counter drugs? ☐ Yes ☐ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____
Signature Date

I understand photos taken of my teeth, smile, or portrait may be displayed for patient educational purposes.

_____
Signature Date