Durfee Family Dentistry
WELCOME

PATIENT INFORMATION (CONFIDENTIAL)

First Name _____ Last Name _____ Middle initial _____

SS# _____-_____-_____ DOB _____-_____-_____ Sex: ☐ M ☐ F Age ____

Home Phone (_____) _____ Cell Phone: (_____) _____ Driving Lic. _____

If student, _____ City _____ State _____ Grade _____ ☐ Full Time ☐ Part Time
School Name

Address: _____ City: _____ State: _____ Zip: _____

Check appropriate: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

FINANCIAL RESPONSIBLE PARTY

Patient's or Parents's Employer: _____ Work Phone #: (_____) _____

Employer address _____ City: _____ State: _____ Zip: _____

Spouse or Parent's name: _____ Employer: _____ Work Phone:(_____)_____

How did you here about this office ☐ Walk in Employer ☐ Flyer ☐ Referred by: _____

Person to contact in case of emergency: _____ Phone #: (_____) _____

Name of person responsible for this account or insured: _____ relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Driver license# _____ DOB _____-_____-_____ SS# _____-_____-_____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of insured: _____ Insurance Company's Name: _____

Group #_____ Policy # _____

Do you have additional insurance coverage: ☐ Yes ☐ No

Do you have MEDI-CAL or any kind of State Aid? ☐ Yes ☐ NO If yes please complete the following

Med-Cal I.D. #: _____

PRIVACY PROTECTION NOTICE

The privacy of your health information is important to us. By signing below I understand that this practice will not share any type of information to any unauthorized person. I have received a copy of notice of privacy.

Patient Signature: _____ Dr's Signature: _____ Date: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above question have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payers of health practitioners. I authorize and request my insurance company to pay directly to dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payments of all services rendered on my behalf of my dependents.

X_____ _____
Signature of patient (or parent of minor) Date

PATIENT MEDICAL HOSTORY

1. Do you have or have you had any of the following? (Please circle)

- High blood pressure ☐ Y ☐ N
- Heart attack ☐ Y ☐ N
- Rheumatic fever ☐ Y ☐ N
- Swollen ankles ☐ Y ☐ N
- fainting / seizures ☐ Y ☐ N
- Asthma ☐ Y ☐ N
- Low blood pressure ☐ Y ☐ N
- Epilepsy / convulsions ☐ Y ☐ N
- Leukemia ☐ Y ☐ N
- Diabetes ☐ Y ☐ N
- Kidney diseases ☐ Y ☐ N
- AIDS or HIV infection ☐ Y ☐ N
- Thyroid problem ☐ Y ☐ N

Heart disease ☐ Y ☐ N
Cardiac pacemaker ☐ Y ☐ N
Heart murmur ☐ Y ☐ N
Angina ☐ Y ☐ N
Frequently tired ☐ Y ☐ N
Anemia ☐ Y ☐ N
emphysema ☐ Y ☐ N
Cancer ☐ Y ☐ N
Arthritis ☐ Y ☐ N
Joint replacement or implant ☐ Y ☐ N
Hepatitis / Jaundice ☐ Y ☐ N
Sexually transmitted disease ☐ Y ☐ N
Stomach trouble / Ulcers ☐ Y ☐ N

Chest pains ☐ Y ☐ N
Easily winded ☐ Y ☐ N
Strike ☐ Y ☐ N
Hay Fever / Allergies ☐ Y ☐ N
Tuberculosis ☐ Y ☐ N
Radiation therapy ☐ Y ☐ N
Glaucoma ☐ Y ☐ N
Recent weight loss ☐ Y ☐ N
Liver disease ☐ Y ☐ N
Heart trouble ☐ Y ☐ N
Respiratory problems ☐ Y ☐ N
Mitral Valve Prolapse ☐ Y ☐ N
OTHER PROBLEM ☐ Y ☐ N

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 yrs(If Yes, please explain _____ ☐ Y ☐ N
3. Are you under medical treatment now? ☐ Y ☐ N
4. Are you taking any medication (s) including Non-prescription medicine _____
If yes, What medication (s) are you taking ☐ Y ☐ N
5. Have you ever taken Phen-Fen / Redux? ☐ Y ☐ N
6. Do you use Tobacco? ☐ Y ☐ N
7. Do you use controlled substance? ☐ Y ☐ N
8. Are you taking any blood pressure medicine? ☐ Y ☐ N

10a (women only) Are you pregnant or think you are? ☐ Y ☐ N
10b (woman only) Are you breast feeding? ☐ Y ☐ N
10c (woman only) Are you taking oral contraceptives? ☐ Y ☐ N

11. Do you have wear a cardiac pace maker or have you had heart surgery ☐ Y ☐ N
12. Are you sensitive or allergic to any drugs?
Local anesthetics (eg. Novocain) ☐ Y ☐ N
Penicillin or any other Antibiotics ☐ Y ☐ N
Sulfa drugs ☐ Y ☐ N
Barbiturates ☐ Y ☐ N
Sedatives/ ☐ Y ☐ N
Lodine ☐ Y ☐ N
Aspirin ☐ Y ☐ N
Any metals (eg. Nickel, mercury etc. ☐ Y ☐ N
Latex rubber ☐ Y ☐ N
Tetracycline ☐ Y ☐ N
Codeine ☐ Y ☐ N
13. Do you have any disease, condition or problem not listed that you think we should know about ☐ Y ☐ N

Physician's name and phone # _____

PATIENT DENTAL HISTORY

Previous dentist Name _____

1. Why are you here today __Check-up __Estimate __Toothache __Other
2. What treatment was performed last?_____
3. When were dental X-Rays last taken?_____
4. Was the last treatment completed? ☐ Y ☐ N
5. Do your gums bleed while brushing or flossing? ☐ Y ☐ N
6. Are your teeth sensitive to hot or cold liquids/foods? ☐ Y ☐ N
7. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Y ☐ N
8. Do you feel pain on any of your teeth? ☐ Y ☐ N
9. Do you have any sores or lumps in or near your mouth? ☐ Y ☐ N
10. Have you had any head, neck, or jaw injuries? ☐ Y ☐ N
11. Do you have frequent headaches? ☐ Y ☐ N
12. Do you clench or grind your teeth? ☐ Y ☐ N
13. Do you bite your lips or cheeks frequently? ☐ Y ☐ N
14. Have you ever had any difficult extractions in the past? ☐ Y ☐ N

Date of last exam: _____

15. Have you ever experienced any of the following problems in your jaw?
Clicking ☐ Y ☐ N
Pain (Joint, ear, side of face) ☐ Y ☐ N
Difficulty in opening and closing ☐ Y ☐ N
Difficulty in chewing ☐ Y ☐ N
16. Have you ever had any prolonged bleeding following extractions? ☐ Y ☐ N
17. Have you had any orthodontic treatment? ☐ Y ☐ N
18. Do you wear dentures or partials? ☐ Y ☐ N
If yes, date of placement_____
19. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Y ☐ N
20. Do you like your smile? ☐ Y ☐ N
21. **Have you ever been pre-medicated with antibiotics for you dental treatment?** ☐ Y ☐ N

CONSENT

I hereby authorize the dentist(s) assisted by other dentist and/or dental auxiliaries of his/her choice, to perform upon myself or my child needed X-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis. I am aware that most frequently used materials in restorative dentistry are amalgam, (alloy mercury) composite resign advantages and disadvantages, benefits and risks. I have had the opportunity to review the dental material fact sheet.

X_____ _____ X _____
Signature of patient (or parent or tutor) Date Dr. Signature

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date _____ Signature _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd UPDATE - Since your last visit:
1. Have you seen a medical doctor? ☐Y ☐N
2. Have you had a change in any medication? ☐Y ☐N
3. Have you had a change in any medical condition Or had surgery? ☐Y ☐N
If yes, please explain: _____
Date_____ Signature: _____
Dr. Signature: _____

3rd UPDATE - Since your last visit:
1. Have you seen a medical doctor? ☐ Y ☐ N
2. Have you had a change in any medication? ☐ Y ☐ N
3. Have you had a change in any medical condition Or had surgery? ☐ Y ☐ N
If yes, please explain: _____
Date_____ Signature: _____
Dr. Signature: _____