

Welcome to Hidden Valley Dental Group

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 _____

SS/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

FOR MINORS:

Mother's Name/Legal Guardian _____ Custodial Parent? Yes No

Father's Name/Legal Guardian _____ Custodial Parent? Yes No

Dental Insurance

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? Yes No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

I, the undersigned certify that I (or my dependent) have dental insurance coverage with _____ and assign directly to Hidden Valley Dental Group all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Dental History

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Reason for today's visit _____

 Former Dentist _____
 City/State _____
 Date of last dental visit _____
 Date of last dental x-rays _____
 How often do you floss? _____
 How often do you brush? _____
 How do you feel about the color/appearance of your teeth?

Bad Breath Yes No
 Bleeding Gums Yes No
 Blisters on lips or mouth Yes No
 Burning sensation on tongue Yes No
 Chew on one side of mouth Yes No
 Cigarette, pipe, or cigar smoking Yes No
 Clicking or popping jaw Yes No
 Dry mouth Yes No
 Fingernail biting Yes No
 Food collection between teeth Yes No
 Foreign objects in mouth Yes No
 Grinding teeth Yes No
 Gums swollen or tender Yes No

Lip or cheek biting Yes No
 Loose teeth or broken fillings Yes No
 Mouth Breathing Yes No
 Orthodontic Treatment Yes No
 Periodontal Surgery Yes No
 Periodontal Treatment Yes No
 Sensitivity to cold Yes No
 Sensitivity to hot Yes No
 Sensitivity to sweets Yes No
 Sensitivity when biting Yes No
 Sores or growth in mouth Yes No
 TMJ Surgery Yes No
 Tobacco Chewing Yes No

Medical History

Physician's Name _____ Date of last visit _____ Blood Type _____
 Phone (____) _____ Pharmacy _____ Phone (____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS Yes No
 Anemia Yes No
 Arthritis, Rheumatism Yes No
 Asthma Yes No
 Back Problems Yes No
 Cancer Yes No
 Chemical Dependency Yes No
 Chemotherapy Yes No
 Circulatory Problems Yes No
 Cortisone Treatments Yes No
 Cough, persistent or bloody Yes No
 Diabetes Yes No
 Emphysema Yes No
 Epilepsy Yes No
 Fainting or dizziness Yes No
 Glaucoma Yes No
 Headaches Yes No
 Heart Problems Yes No
 Hepatitis Type B or C Yes No
 Hemophilia Yes No

Herpes Yes No
 High Blood Pressure Yes No
 HIV Positive Yes No
 Jaundice Yes No
 Jaw Pain Yes No
 Kidney Disease Yes No
 Liver Disease Yes No
 Low Blood Pressure Yes No
 Nervous Problems Yes No
 Psychiatric Care Yes No
 Radiation Treatment Yes No
 Respiratory Disease Yes No
 Scarlet Fever Yes No
 Shortness of Breath Yes No
 Special Diet/Weight Loss Yes No
 Swollen Feet or Ankles Yes No
 Swollen Neck Glands Yes No
 Thyroid Problems Yes No
 Tonsillitis Yes No
 Tuberculosis Yes No

Tumors or Growths Yes No
 Ulcer Yes No
 Venereal Disease Yes No

Have you ever had or been diagnosed with:

Angioplasty Yes No
 Artificial Heart Valves Yes No
 Artificial Joints, Screws, Pins Yes No
 Bleeding abnormally, with extractions or surgery Yes No
 Blood Disease Yes No
 Congenital Heart Lesions Yes No
 Heart Murmur Yes No
 Mitral Valve Prolapse Yes No
 Organ Transplant Yes No
 Pacemaker Yes No
 Rheumatic Fever Yes No
 Heart Attack/Stroke Yes No
 If yes, please give date _____

Have you ever had any complications following dental treatment? Yes No
 If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? Yes No
 If yes, please describe _____

Women: Are you pregnant? Yes No
 Due Date _____
 Are you nursing? Yes No
 Taking birth control pills? Yes No

Have you ever taken any of these medications?

Blood Thinners Yes No
 Aspirin Yes No
 Coumadin Yes No
 Warfarin Yes No
 Diet Medications Yes No
 Fen-Phen Yes No
 Insulin Yes No
 Levoxy Yes No
 Nitroglycerin Yes No
 Ritalin Yes No
 Synthroid Yes No

Are you allergic to:

Acrylic Yes No
 Amoxicillin Yes No
 Aspirin Yes No
 Codeine Yes No
 Ibuprofen Yes No
 Iodine Yes No
 Latex Yes No
 Local Anesthesia Yes No
 Metals (i.e. nickel, amalgam) Yes No
 Penicillin Yes No
 Other _____

Please PRINT all medications you are taking and for what reason: _____

CERTIFICATION

To the best of my knowledge, all of the information provided here is true and correct. If I ever have any changes in my health, I will inform the dentist at the next appointment without fail.

Signature _____ Date _____
Signature of Adult Patient, Parent or Guardian

Doctor's Comments & Updates

(To be completed by the Dentist)

Medical Clearance Letter Sent to _____ Date _____
 Results _____
 Doctor's Signature _____ Date _____