A+ FAMILY DENTISTRY

6755 MIRA MESA BLVD., STE 218 * SAN DIEGO, CA 92121

858.412.4933 * aplusfamilydentistry.com

PATIENT INFORMATION (Confidential)

NAME_____ M __ F __
FIRST MIDDLE LAST SEX

ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMAIL_____ SS#_____ BIRTHDATE_____ AGE _____

PHONE: CELL_____ WORK_____ BEST TIME TO CALL_____

IF WE HAVE ANY CHANGES TO OUR SCHEDULE MAY WE CONTACT YOU? YES ___ NO ___

CHECK APPROPRIATE: MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED ___

IF COLLEGE STUDENT: FULL TIME ___ PART TIME ___ SCHOOL NAME_____ CITY_____ STATE _____

PATIENT'S OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS_____ CITY_____ STATE_____ ZIP_____

SPOUSE OR PARENT'S NAME_____

EMPLOYER_____ WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____

RESPONSIBLE PARTY (Confidential)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT_____ ADDRESS _____

PHONE_____ SS#_____ DRIVERS LISCENSE # _____

BIRTHDATE_____ EMPLOYER_____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES ___ NO ___

X _____ DATE_____
SIGNATURE OF PATIENT OR PARENT IF MINOR

MEDICAL HISTORY (Confidential)

	YES	NO
1. ARE YOU IN GOOD HEALTH?	___	___
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	___	___
3. DATE OF YOUR LAST PHYSICAL EXAM: _____		
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	___	___
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? PLEASE EXPLAIN _____	___	___
7. ARE YOU TAKING ANY MEDICINES INCLUDING NONPRESCRIPTION MEDICINES? IF YES, WHAT ARE YOU TAKING? _____	___	___
8. BRUISE EASILY OR ABNORMAL BLEEDING?	___	___
9. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	___	___
10. HAVE YOU HAD A RECENT WEIGHT LOSS?	___	___
11. HAVE YOU EVER TAKEN FEN-PHEN OR REDUX?	___	___
12. HAVE YOU EVER HAD BIPHOSPHONATE DRUGS FOR CANCER OR OSTEOPOROSIS?	___	___
13. DO YOU USE TOBACCO?	___	___
14. DO YOU OR HAVE YOU USED CONTROLLED DRUGS?	___	___
15. ARE YOU WEARING CONTACT LENSES?	___	___
16. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT?	___	___
17. WOMEN:		
Are you pregnant?	___	___
Are you nursing?	___	___
Are you Taking Birth Control Pills?	___	___
18. ARE YOU ALLERGIC TO OR HAVE YOU HAD SERIOUS REACTIONS (other than stomach upset) TO:		
Local Anesthetics like Novocain	___	___
Penicillin or Other Antibiotics	___	___
Sulfa Drugs	___	___
Barbiturates, Sedatives or Sleeping Pills	___	___
Aspirin or Similar NSAIA's	___	___
Iodine or Shellfish	___	___
Any Metals or Latex	___	___
OTHER (please list) _____		

19. DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:

	YES	NO
Rheumatic Heart Disease or Rheumatic Fever	___	___
Scarlet Fever	___	___
Heart Defect/Murmur, Mitral Valve Prolapse	___	___
Heart Surgery, Trouble, Attack, or Angina	___	___
Chest Pain, Shortness of Breath, Pacemaker	___	___
High / Low Blood Pressure	___	___
Sinus trouble	___	___
Lung or Breathing Problems Asthma or Hay Fever	___	___
Hives or Skin Rash	___	___
Fainting or Dizzy Spells	___	___
Diabetes	___	___
AIDS or HIV Infection	___	___
Thyroid Problems	___	___
Allergies	___	___
Arthritis, rheumatism, fibromyalgia	___	___
Joint Replacement or Any Implant	___	___
Stomach Ulcer, Reflux, IBS, Crohn's	___	___
Kidney Trouble	___	___
Tuberculosis, Persistent or Bloody Cough	___	___
Chemotherapy for Cancer or Leukemia	___	___
Sexually Transmitted Disease	___	___
Epilepsy or Seizures, M.S.	___	___
Anemia or Blood Disorders	___	___
Glaucoma	___	___
Nervousness or Phobias	___	___
Tumors or Cancer	___	___
Back Problems	___	___
Chemical Dependency, Addictions	___	___
Cortisone Treatment	___	___
Cold Sores / Fever Treatment Hypoglycemia	___	___
Eating Disorders, Bulimia, Anorexia	___	___
Chronic Pain Condition	___	___
Head or Neck Trauma, Whiplash	___	___
Hyperchondriosis	___	___
Mental Health Care: Diagnosis _____		
Other _____		

DENTAL HISTORY (Confidential)

Reason for This Visit: _____

Date of Last Dental Visit: _____

What was done? _____

Previous dentist name / location: _____

Current home care: How often do you brush?_____ Floss?_____

Circle all that you are concerned about / currently have:

Sensitivity to: Hot *or* Cold *or* Sweets		Tooth Pain / Ache
Cavities	Gum disease	Pain to Bite
Broken Teeth	Broken Fillings	Missing Teeth
Dark Teeth	Ugly Teeth	Crooked Teeth
Bad Breath	Clicking jaw	Fear of Dentist
Loose Teeth	Spacing	Grinding / Clenching
Jaw or Face Pain	Headaches	Want whiter teeth
Want to Save Teeth	Poor dentistry	Want Gentle Dentist
Dream Teeth Fall Out	Recession	Cosmetic Dentistry
Snoring / Apnea	Bleeding Gums	Nothing

I am changing dentists because: (Check any that apply)

___ Recently moved into this area from_____
___ Dr / Staff Personality - Communication Problem
___ Inadequate Care - Fee Concern - Insurance
___ I need a second opinion or better option on dental care.
___ To find a dentist team who understands my needs.

I have avoided dental care in the past because:

___ Time commitment
___ Financial commitment
___ No perceived need
___ Trust factor
___ Fear of _____

Are you interested in exploring (check any that apply):

___ Dental wellness (going beyond good health)
___ Ways to reduce or eliminate periodontal surgery
___ Invisalign invisible orthodontic aligners
___ ZOOM office whitening or home whitening
___ The best dental home care system (Sonicare ETB)
___ A good restaurant in the area
___ I.V. Sedation and Sleep Dentistry
___ Sedation Dentistry (taking a pill) options
___ Smile Makeover -- Smile Analysis & Design
___ Why dental infections cause heart & other diseases

If you could change anything about your smile, what would you change? _____

Your occupation and job: _____

Schools attended: _____

Spouse's name & occupation: _____

Children's names, ages? _____

Where are you from originally? _____

What's more fun than dental visits? _____

How did you first hear about us? (Check any that apply)

___ Family member already comes here
___ Referred by a friend -Who?
___ Convenient location (Walking by)
___ I received your Magazine in the mail
___ I got a postcard in the Mail
___ I Saw your Internet web site
___ I dreamed I should come here
___ Social media links: ___ Facebook ___ LinkedIn
___ I prayed for help and here I am

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____ , have received a copy of this office's Notice of Privacy Practices.

x _____ Date _____
Signature of Patient or Parent if Minor

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to dental examination and any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models or photos for scientific, teaching or promotional purposes.

x _____ Date _____
Signature of Patient or Parent if Minor