ADVANCED
DENTISTRY
THE ART OF THE SMILE

PATIENT INFORMATION UPDATE

DATE _____ INITIALS _____

DATE _____ INITIALS _____

Patient Information

DATE _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____

□ MALE □ FEMALE

SOCIAL SECURITY # _____

DRIVER'S LICENSE # _____

□ MARRIED □ SINGLE □ OTHER

EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

POSITION _____

HOME PHONE # _____

OFFICE PHONE # _____

CELL PHONE # _____

E-MAIL ADDRESS _____

INFORMATION ABOUT YOUR SPOUSE

NAME _____

DATE OF BIRTH _____ AGE _____

SOCIAL SECURITY # _____

ADDRESS EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

POSITION _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

We are happy to assist by submitting your insurance claim for you. Please complete the following information:

PRIMARY CARRIER

NAME OF INSURED _____

SOCIAL SECURITY # _____

INSURANCE CARRIER _____

EMPLOYER EMPLOYER

GROUP # _____ DOB _____

SECONDARY CARRIER

NAME OF INSURED _____

SOCIAL SECURITY # _____

INSURANCE CARRIER _____

EMPLOYER _____

GROUP # _____ DOB _____

GENERAL INFORMATION

CONVENIENT APPOINTMENT TIME _____

ARE YOU AVAILABLE FOR APPOINTMENT ON SHORT NOTICE? _____

TIME OF DAY _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

_____

THEIR PHONE # _____

PERSON RESPONSIBLE FOR ACCOUNT _____

_____

RELATIONSHIP TO PATIENT _____

DRIVER'S LICENSE # _____

BANK _____

BRANCH _____

** PLEASE FILL OUT BOTH SIDES **

556 BATTERY STREET
SAN FRANCISCO · CA · 94111

TEL: 415/398-5200
FAX: 415/398-3430

MEDICAL HISTORY

(PLEASE ANSWER ALL QUESTIONS)

PLEASE CIRCLE YES OR NO:			IF YES, EXPLAIN:
RHEUMATIC FEVER	NO	YES	
HEART MURMUR	NO	YES	
HIGH BLOOD PRESSURE	NO	YES	
CIRCULATION PROBLEMS	NO	YES	
EXCESSIVE BLEEDING	NO	YES	
HEPATITIS	NO	YES	
VENEREAL DISEASE	NO	YES	
AIDS	NO	YES	
ANEMIA	NO	YES	
DIABETES	NO	YES	
KIDNEY DISEASE	NO	YES	
RESPIRATORY DISEASE	NO	YES	
TUBERCULOSIS	NO	YES	
SINUS PROBLEMS	NO	YES	
ASTHMA	NO	YES	
HAY FEVER	NO	YES	
ULCERS	NO	YES	
ARTHRITIS	NO	YES	
TUMORS OR GROWTHS	NO	YES	
RADIATION TREATMENT	NO	YES	
SPELLS	NO	YES	
NERVOUS DISORDERS	NO	YES	
EPILEPSY	NO	YES	
HEAD/NECK INJURIES	NO	YES	
STROKE	NO	YES	

ARE YOU IN GOOD HEALTH? _____

DATE OF LAST MEDICAL EXAM _____

HAVE YOU EVER BEEN HOSPITALIZED? _____

IF SO, WHAT WAS THE PROBLEM? _____

_____

DO YOU WEAR CARDIAC PACEMAKER? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____

IF YES, FOR WHAT? _____

_____

ARE YOU PREGNANT? _____ HOW MANY MONTHS? ___

LIST ANY DRUGS OR CHEMICALS THAT YOU ARE SENSITIVE TO:

_____

ANY ALLERGIES TO LATEX? _____

LIST ANY DRUGS YOU ARE NOW TAKING: _____

_____

HAVE YOU EVER TAKEN PHEN-FEN? _____

DO YOU HAVE OTHER DISEASE, FAINTING PROBLEM OR CONDITION THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT?

_____

PHYSICIAN'S NAME: _____

DENTAL HISTORY

(PLEASE ANSWER ALL QUESTIONS)

HOW LONG SINCE YOU'VE BEEN TO THE DENTIST? _____

HAVE YOU EVER HAD AN UNFAVORABLE EXPERIENCE WITH A DENTIST? _____

IS THERE ANYTHING WE CAN DO TO MAKE YOU FEEL MORE COMFORTABLE WHILE RECEIVING TREATMENT?

- ☐ NITROUS OXIDE
- ☐ STEREO HEADPHONES (YOU ARE WELCOME TO BRING YOUR CHOICE OF CASSETTE TAPES OR CD'S)
- ☐ OTHER

WHEN WERE YOUR LAST SET OF X-RAYS TAKEN? _____

DISEASE PROBLEMS OR CONDITION THAT YOU HAVE BEEN INSTRUCTED IN THE CARE OF YOUR GUMS? _____

HAVE YOU BEEN TREATED FOR PERIODONTAL (GUM) DISEASE?

DO YOU HAVE ANY SORES, BLISTERS, OR SWELLING ON YOUR GUMS, LIPS OR CHEEKS? _____

DO YOU GRIND OR CLENCH YOUR TEETH? _____

HAVE YOU EVER HAD POPPING OR CLICKING NEAR YOUR EAR WHEN YOU CHEW? _____

HAVE YOU HAD ORTHODONTIC TREATMENT? _____

DO YOU, OR HAVE YOU HAD ANY DENTAL DISEASE PROBLEMS OR CONDITION THAT HASN'T BEEN MENTION? _____

PLEASE EXPLAIN _____

_____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I ATTEST TO THE ACCURACY OF THE INFORMATION ON THIS FORM.

PATIENT OR GUARDIAN'S SIGNATURE: _____ DATE: _____

I CERTIFY THAT I HAVE REVIEWED THE MEDICAL HISTORY WITH THE PATIENT: _____

DOCTOR SIGNATURE