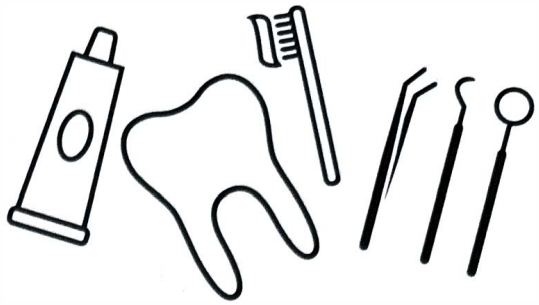
WELCOME
TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist your dental needs.

PATIENT INFORMATION

DATE_____ Soc. Sec. # _____ BIRTHDATE _____

FULL NAME _____

HOME #_____ CELL #_____ WORK #_____

ADDRESS _____
CITY STATE ZIP

EMAIL _____

SEX: ___ Male ___ Female ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMPLOYER _____
NAME ADDRESS CITY STATE ZIP

Who should we thank for referring you? _____

In case of an emergency, who should we contact?

_____
NAME RELATION PHONE #

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE I.D. #/SSN GROUP #

INSURANCE PHONE # MAILING ADDRESS

INSURANCE HOLDER'S NAME RELATION Date of Birth

EMPLOYER NAME ADDRESS PHONE #

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE I.D. #/SSN GROUP #

INSURANCE PHONE # MAILING ADDRESS

INSURANCE HOLDER'S NAME RELATION Date of Birth

EMPLOYER NAME ADDRESS PHONE #

-Please complete reverse side-

DENTAL HISTORY

What is the reason for your visit today?_____

FORMER DENTIST PHONE #

PLEASE CHECK ALL THAT APPLY

- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Periodic Treatment
- ☐ Bleeding Gums
- ☐ Jaw Clicking/Popping
- ☐ Sensitivity to Cold/Hot or when Biting
- ☐ Blisters on Lip/Mouth
- ☐ Loose Teeth/Broken Fillings
- ☐ Sensitivity to Sweets
- ☐ Food Collection
- ☐ Orthodontic Treatment

MEDICAL HISTORY

PHYSICIAN PHONE #

PHARMACY LOCATION PHONE #

1. Are you under medical treatment now? If so, please explain: _____
2. Have you had any surgeries? If so, please explain:_____
3. Do you have any artificial joints? If so, please explain: _____
4. To your knowledge, do you need to be pre-medicated before dental treatment? _____
5. (For women only) Are you: **Pregnant?** ☐ YES ☐ NO **Nursing?** ☐ YES ☐ NO **Taking birth control pills?** ☐ YES ☐ NO
6. Are you allergic to any medications? If so, please list: _____
7. Please attach a list of all medications you are currently taking or list all medications below:

PLEASE CHECK ALL THAT APPLY

- ☐ ADD/ADHD
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rhematic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid
- ☐ Tonsilitis
- ☐ Ulcer

I hereby authorize Dr. Casillas & Dr. Barrera's Dental office to perform advisable/necessary dental procedures, administer medications, or anesthetics for diagnostic and dental treatment; to obtain and disclose health information for myself and dependents from medical/dental providers; and to release information required to secure payment of services. I understand that payment will be made to my provider for all insurance benefits and that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf and on behalf of my dependents.

Patient Signature_____ Date_____