sda | Sunnyvale Dental Aesthetics

www.DavidMengDDS.com

Welcome to our Practice ☺

Date_____

Patient Information

Name _____ **Birthdate** _____

SSN _____ **Sex:** □ Male □ Female **Status:** □ Married □ Single □ Divorced □ Seperated □ Other

Mobile Phone #_____ Work # _____ Home # _____

Address _____ City _____ State _____ Zip_____

Email_____ Alternate Phone # _____

Who may we thank for your referral? _____

Emergency Contact Name & Phone Number _____

Insurance Information

Name of Primary Cardholder_____ Birthdate_____

Relation to Patient_____ Employer _____

SSN or ID _____ Date Employed (estimate) _____ Group _____

Insurance Company _____ Insurance Phone # _____

Secondary Insurance Information (if applicable)

Name of Primary Cardholder_____ Birthdate_____

Relation to Patient_____ Employer _____

SSN or ID _____ Date Employed (estimate) _____ Group _____

Insurance Company _____ Insurance Phone # _____

Dental History

Do you have a specific dental problem? Describe_____ ☐ Yes ☐ No

Do you have dental exams on a routine basis? When was your last dental visit?_____ ☐ Yes ☐ No

Do you have active decay or gum disease? _____ ☐ Yes ☐ No

Do you brush and floss on a routine basis? Discuss _____ ☐ Yes ☐ No

Do your gums ever bleed? Discuss _____ ☐ Yes ☐ No

Any loose teeth? _____ ☐ Yes ☐ No

Do you ever have clicking, popping or discomfort in the jaw? Do you bruxism or grind? _____ ☐ Yes ☐ No

Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ ☐ Yes ☐ No

Name of previous Dentist (optional): _____

Date of last full mouth X-ray or Pano X-ray? _____ Date of Last Regular X-Rays? _____

Medical History

Are you under a physician's care now? Why? _____ ☐ Yes ☐ No

Had you ever been hospitalized or had a major operation? Discuss_____ ☐ Yes ☐ No

Have you ever had a serious injury to your head or neck? Discuss _____ ☐ Yes ☐ No

Are you taking any pills, medications or drugs? What? _____ ☐ Yes ☐ No

Are you on a special diet? Discuss _____ ☐ Yes ☐ No

Do you have any drug or food allergies? What? _____ ☐ Yes ☐ No

Have you or are you currently taking bisphosphonates? (Fosamax, Reclast, Actonel, or Boniva) _____ ☐ Yes ☐ No

Women (Please check): ◯ Pregnant ◯ Trying ◯ Nursing ◯ Taking Oral Contraceptives

Do you now have or have ever had any of the following? Please circle any conditions that you have or had in the past:
(*If yes to any of the starred conditions, please call prior to your appointment…premedication might be required)

Heart Murmur*	Herpes	Fainting or Dizziness	Hypoglycemia
Mitral Valve Prolapse*Heart	Angina/Chest Pain	Scarlet Fever	AIDS or HIV
Rheumatic Fever*	Sickle Cell Disease	Swelling of Limbs	Alzheimer 's disease
Artificial Joint*	Radiation Treatment	Recent Weight Loss	High Blood Pressure
Trouble/Disease	Thyroid Disease	Pain in Jaw Joint	Hay Fever
Heart Pace Maker*	Stroke	Glaucoma	Liver Disease
Artificial Heart Valve*	Heart Attack/Failure	Lung Disease	Low Blood Pressure
Bruise Easily	Hemophilia (Bleeding Problem)	Frequent Diarrhea	Sinus Trouble
Emphysema	Chemotherapy	Cortisone Medicine	Hepatitis A
Yellow Jaundice	Parathyroid Disease	Tumors	Allergies (Pollen/Dust)
Cold Sores	Convulsions	Breathing Problems	Blood Disease
Anemia	Congenital Heart Disorder	Diabetes	Asthma
Tuberculosis	Leukemia	Nervousness	Hepatitis B or C
Kidney Problems	Stomach/Intestinal Disease	Shortness of Breath	Drug Addiction/Alcoholism
Fever Blisters	Arthritis/Gout	Excessive Thirst	Hives or Rash
Irregular Heart Beat	Epilepsy or Seizure	Venereal Disease	Unexplained Fever
Excessive Bleeding	Recent Blood Transfusion	Psychiatric Care	Bloody Sputum
Cancer	Ulcers	Heart Surgery	Night Sweats
Renal Dialysis	Rheumatism	Frequent Cough	

Have you ever had any other serious illness not checked above? Discuss_____ ☐ Yes ☐ No

Do you wish to talk to the dentist privately about any problem? _____ ☐ Yes ☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status of if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

PATIENT SIGNATURE X_____ Date _____

(OR if under 18 years old, PARENT/GUARDIAN Signature)

Reviewed by Doctor_____ Date _____

History Review and Significant Findings _____

Medical Updates

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	None □	_____	Dr._____
_____	_____	None □	_____	Dr._____
_____	_____	None □	_____	Dr._____
_____	_____	None □	_____	Dr._____
_____	_____	None □	_____	Dr._____

Sunnyvale Dental Aesthetics

Office Policies & Consents

☐ CANCELLATION POLICY – Failure to notify the office within 48 hours of an appointment cancellation will be subject to a $50 fee.

☐ INFORMATION UPDATE – Please update us with any changes to your insurance coverage, health/medical conditions, phone numbers, addresses, email address, and/or employer.

☐ HIPAA – I understand that all personal health information obtained by this office will be kept confidential in accordance to HIPAA regulations.

☐ DENTAL MATERIALS FACT SHEET – I have received and reviewed the Dental Materials Fact Sheet developed by the Dental Board of CA.

Your signature below indicates you have read, understand and agree to these policies.

Patient/Guardian Signature _____

Patient Name _____ Date _____

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