Thank You for selecting Trabuco Dentistry!

To help us meet your healthcare needs, please complete the form in full. If you need assistance or have any questions, feel free to ask us, we will be happy to help!

Patient Information

Name: Birthdate:

Address: City: State: Zip:

Home# Cell # Work#

SS#/ SIN: Driver's License #

Marital Status:

Emergency Contact Name Emergency Contact Phone #

Insurance Information

Name of Insured: Relationship to Patient:

Birthdate: SS#/ SIN:

Name of Employer: Work #:

Insurance Company: Group#:

Policy #: Insurance Phone#:

Secondary Insurance: ☐ Yes ☐ No

Name of Insured: Relationship to Patient:

Birthdate: SS#/ SIN:

Name of Employer: Work #:

Insurance Company: Group#:

Policy #: Insurance Phone#:

Patient Medical History

Physician: Office #: Date of Last Exam:

Are you under treatment now? ☐ Yes ☐ No Are you taking any medication(s) ☐ Yes ☐ No

Including non-prescription medicine?

Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years, if so explain? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing Bisphosphonates? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No

Are you wearing contact lens? ☐ Yes ☐ No

Do you have a persistent cough or throat clearing not associated with a known illness? ☐ Yes ☐ No

Woman Only:

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking any oral contraceptives? ☐ Yes ☐ No

Penicillin or any other Antibiotics ☐ Yes ☐ No

Sulfa Drugs ☐ Yes ☐ No

Barbiturates ☐ Yes ☐ No

Sedatives ☐ Yes ☐ No

Iodine ☐ Yes ☐ No

Aspirin ☐ Yes ☐ No

Any Metals ☐ Yes ☐ No

Latex Rubbers ☐ Yes ☐ No

Other

Are you allergic to or have you had any allergic reactions to the following?

Local Anesthetics (e.g Novocain) ☐ Yes ☐ No

Do you or have you had any of the following?

High Blood Pressure ☐ Yes ☐ No

Heart Attack ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Fainting/ Seizures ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Low Blood Pressure ☐ Yes ☐ No

Epilepsy/ Convulsions ☐ Yes ☐ No

Leukemia ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Kidney Diseases ☐ Yes ☐ No

AIDS or HIV Infection ☐ Yes ☐ No

Thyroid Problem ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Cardiac Pacemaker ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Angina ☐ Yes ☐ No

Emphysema ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Joint Replacement or Implant ☐ Yes ☐ No

Sexual Transmitted Disease ☐ Yes ☐ No

Hepatitis/ Jaundice ☐ Yes ☐ No

Stomach Trouble/ Ulcers ☐ Yes ☐ No

Chest Pains ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Hay Fever/ Allergies ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Radiation Therapy ☐ Yes ☐ No

Liver Disease ☐ Yes ☐ No

Heart Trouble ☐ Yes ☐ No

Repertory Problems ☐ Yes ☐ No

Mitral Valve Prolapse ☐ Yes ☐ No

Other: _____

Patient Dental History

Name of Previous Dentist _____ Previous Dentist Location _____

Date of Last Exam _____ Date of Last Cleaning _____

Do your gums bleed while flossing/ brushing? ☐ Yes ☐ No

Are your teeth sensitive to hot/ cold liquids/foods? ☐ Yes ☐ No

Are your teeth sensitive to sweet/ sour liquids/ foods? ☐ Yes ☐ No

Do you feel any pain in your mouth? ☐ Yes ☐ No

Have you ever had jaw, neck and/ or head injures? ☐ Yes ☐ No

Have you ever experienced and of the following problems in your jaw?

Clicking ☐ Yes ☐ No

Pain (joint, ear, side of face) ☐ Yes ☐ No

Difficulty in closing or opening ☐ Yes ☐ No

Difficulty in chewing ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you bite your lips or cheeks?

☐ Yes ☐ No

Have you had ortho treatment?

☐ Yes ☐ No

Have you ever had a difficult

☐ Yes ☐ No

extraction in the past?

Do you have dentures or partials?

☐ Yes ☐ No

Have you ever had any

☐ Yes ☐ No

prolonged bleeding?

Have you ever received oral

☐ Yes ☐ No

hygiene instructions regarding the care of your teeth and gums?

Do you like your smile?

☐ Yes ☐ No

Release and Authorization

I herby certify I have read and understand the above information to the best of my knowledge and the above questions have been answered correctly. I do understand that by providing false/ incorrect information can be dangerous to my heath. I authorize the Dr. Bal to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such Dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to Trabuco Dentistry/ Dr. Bal or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Signature of Patient (or parent/ guardian if minor)