ARBOR DENTAL GROUP

3151 So. White Road, Suite 104 • San Jose, California 95148 • Tel. (408) 270-2273

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office ? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Ph # ( ) _____ Cell Ph # ( ) _____ Work Ph # ( ) _____ Soc Sec. # ___ - ___ - ___ Drivers Lic # _____

Birthday ____ /____/ _____ If patient is a minor, give parent's/ guardians name _____

If patient is a full-time student fill in school name _____ email: _____

Name of nearest relative not living with you _____ Relationship _____

Complete address _____ Ph # ( ) _____

Emergency Contact _____ Ph # ( ) _____

Responsible Party Information

Name _____ SSN _____ D.O.B. _____

Home Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Employed by _____ Occupation _____ Email: _____

Dental Insurance Company _____ Group No _____

Address _____ Phone _____

Spouse name _____ SSN _____ D.O.B. _____

Home Address if different _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Employed by _____ Occupation _____ Email: _____

Dental Insurance Company _____ Group No _____

Address _____ Phone _____

Dental Information

Do your gums bleed when you brush ? Yes _____ No _____

Are your teeth sensitive to heat or cold ? Yes _____ No _____ Pressure Yes _____ No _____ Sweets Yes _____ No _____

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

Do you have any fear of dental work ? Yes _____ No _____

Date of Last dental examination _____ What was done at the time ? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem ?

_____

_____

How do you feel about the appearance of your teeth ?

_____

Medical Information

1. Are you having pain or discomfort at this time ? ---------- YES NO
2. Have you been a patient in the hospital during the past two years ? ---------- YES NO
3. Are you now taking any medication or drugs ? ---------- YES NO
   If yes, please list: _____
4. Have you taken any medication of drugs during the past two years including appetite suppressants - fen-phen (fenluramine & phenthermine) or dexfenfluramine or fenflurameine ? ---------- YES NO
5. Have you been under the care of medical doctor during the past two years or since taking any of the appetite suppressants named above? YES NO
   Physician's Name _____ Phone No ( ) _____
   Address _____
6. Are you sensitive or allergic to any medication or anesthetics ? ---------- YES NO
   If yes, please list: _____
7. Indicate which of the following you have had or have present. Circle "YES" or "NO": to each item.

Do you smoke?	YES	NO	Sickle Cell Disease	YES	NO	Allergy to latex	YES	NO
Heart Failure	YES	NO	Artificial Joints (hip,knee,etc.)	YES	NO	Allergy to Metal (Jewelry,etc)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B Serum	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	YES	NO	Developmentally Disabled	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ---------- YES NO
9. Do your ankles swell during the day ? ---------- YES NO
10. Do you use more than two pillows to sleep ? ---------- YES NO
11. Have you lost or gained more than 10 pounds in the past year ? ---------- YES NO
12. Do you ever wake up from sleep and feel short of breath ? ---------- YES NO
13. Are you on a special diet ? ---------- YES NO
14. Do you have or have you had any disease, condition or problem not listed above ? ---------- YES NO
    If yes Please list : _____
15. Do you need to be premedicated prior to dental treatment ? ---------- YES NO

FOR WOMEN ONLY :

Are you pregnant ? ◯ Yes, what month ? _____ Are you nursing , ◯ Yes ◯ No Are you taking birth control pills? ◯ Yes ◯ No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient signature _____ **Date** _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aide deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____
   I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Patient _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE : Reviewed by Dr. _____ Date _____