

**PATIENT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**Dental History**

Please Circle

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No  
 Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No  
 Do you think 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  
 Do you like your smile? Why? \_\_\_\_\_ Yes No  
 Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No  
 Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No  
 Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No  
 Have your past experiences in a dental office always been positive? \_\_\_\_\_ 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-rays (16 small films or panoramic): \_\_\_\_\_

**Medical History**

Are you under a physician's care now? Why? \_\_\_\_\_ Phone \_\_\_\_\_ Yes No  
 Have 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 medications, pills or Biphosphonate drugs like Fosamax or Boniva? \_\_\_\_\_ Yes No  
 Are you on a special diet? Discuss \_\_\_\_\_ Yes No  
 Are you allergic to any medications or substances? Please check box below  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_  
 Women (Please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No				
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint *	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker *	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen / Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>

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 or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.*

X \_\_\_\_\_ Date \_\_\_\_\_  
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

**Medical Updates**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	NONE	PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____
_____	_____	<input type="checkbox"/>	_____	_____	Dr. _____

Jovita A. Barcena, D.M.D.

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**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MARRIED  SINGLE  MINOR  MALE  FEMALE  
LAST FIRST M

ADDRESS \_\_\_\_\_  
STREET APT. # CITY STATE ZIP

BIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME# WORK# FAX# E-MAIL#

PLACE OF EMPLOYMENT \_\_\_\_\_ SS# \_\_\_\_\_

IF FULL TIME STUDENT, SCHOOL NAME \_\_\_\_\_ GRADE \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER

**INSURANCE INFORMATION**

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION  
ADULTS - COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME #	WORK#	FAX#	E-MAIL#	HOME #	WORK#	FAX#	E-MAIL#
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Outside of Immediate Family Household  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_  
Telephone # \_\_\_\_\_

Has any member of your family ever been treated in our office?

Yes  No

Whom may we thank for referring you to our office?  
\_\_\_\_\_

**METHOD OF PAYMENT**

Responsible party currently has an account with this office  
 Yes  No  
 Payment in full at each appointment (cash or personal check)  
 Payment in full at each appointment ( VISA  MC  OTHER)  
Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 I wish to discuss the Dental Office's Financial Policy

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X \_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_ Date State Driver's License # \_\_\_\_\_

**SERVICE CHARGE**

If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.