Welcome to Bay Area Dental Office

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Name ______________________________
Last First Middle

Address ______________ City ______________ State ____ Zip ______

Birthdate __ / __ / __ Soc. Sec.# ______________ Email: ______________

Home Phone ______________ Gender: ◯ *Male* ◯ *Female* ◯ *Other*

Do you have any immediate family who may be a patient at our office? Who? ______________

Who may we notify in case of emergency ______________

Patient Information

Subscriber Name ______________ Relationship to Patient: ______________

Subscriber Birthdate ______________ Subscriber Soc.Sec.# ______________

Employed by ______________ Occupation ______________ Work Phone ______________

Dental Insurance Company ______________ Insurance Phone ______________ Group# ______________

Is patient covered by additional insurance? If yes, what is the insurance name? ______________

Medical History

Physician's Name ______________ Phone: ______________

Date of last visit ______________

If yes, reason for visit... ______________

Have you ever had a blood transfusion? *Yes / No*

Are you pregnant? *Yes / No* Nursing? *Yes / No*

Have you had any serious illnesses or operations? *Yes / No*

Are you currently under physician care? *Yes / No*

Have you ever taken Fen-Phen/Redux? *Yes / No*

Taking birth control pills? *Yes / No*

Please circle yes or no whether have had any of the following:

Y / N	AIDS/HIV Positive	Y / N	Anaphylaxis	Y / N	Anemia	Y / N	Arthritis Rheumatism
Y / N	Artificial joints	Y / N	Asthma	Y / N	Atopic (allergy prone)	Y / N	Blood disease
Y / N	Cancer	Y / N	Chemical dependency	Y / N	Chemotherapy	Y / N	Epilepsy
Y / N	Back problems	Y / N	Cough, Persistent	Y / N	Cough up blood	Y / N	Diabetes
Y / N	Liver Malfunction	Y / N	Circulatory treatments	Y / N	Fainting	Y / N	Heart murmur
Y / N	Jaw pain	Y / N	Food allergies	Y / N	Glaucoma	Y / N	Headaches
Y / N	High blood pressure	Y / N	Nervous problems	Y / N	Pacemaker/Heart surgery	Y / N	Psychiatric care
Y / N	Radiation treatment	Y / N	Cortisone treatments	Y / N	Rapid weight gain or loss	Y / N	Liver disease
Y / N	Skin rash	Y / N	Tuberculosis	Y / N	Rheumatic/Scarlet fever	Y / N	Shingles
Y / N	Shortness of breath	Y / N	Artificial heart valves	Y / N	Mitral Valve Prolepses	Y / N	Arthritis Rheumatism
Y / N	Herpes	Y / N	Pacemaker	Y / N	Spinal Bifida	Y / N	Kidney disease/malfunction
Y / N	Surgical implants	Y / N	Respiratory disease	Y / N	Hepatitis	Y / N	Allergic to Latex, Metal, chemical
Y / N	Tobacco habit	Y / N	Tonsillitis	Y / N	Ulcer/Colitis	Y / N	Hemophilia/Abnormal bleeding
Y / N	Heart problems	Y / N	Stroke	Y / N	Thyroid disease or malfunction	Y / N	Swelling of feet

Do you havea any drug alergies? If yes, list all... ______________

Are you currently taking Medications?If yes, list all... ______________

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used for the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical history, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ______________ Date: ______________