RANDHAWA DENTISTRY

HOW DID YOU FIND OUT ABOUT OUR OFFICE? PLEASE CHECK ONE: □ POSTCARD/FLYER □ WEBSITE

□ A PATIENT OF OURS - Please name:____ □ OTHER ________________________

PATIENT INFORMATION

NAME ____-____________________________-____________________________________
FIRST MIDDLE LAST

ADDRESS____

TELPHONE: HOME # ____ CELL #_______________________________________

EMAIL ADDRESS ____

EMPLOYER/ OCCUPATION NAME ____

SOC. SEC. # __________-________- ____________

DATE OF BIRTH________/________/____________ MALE □ FEMALE □ MARRIED: YES □ NO □

If married SPOUSE'S NAME: ____ TEL#_____________________________

DATE OF BIRTH ________/________/____________ SOC. SEC. #__________-_________-_____________

EMPLOYER INFORMATION ____

IF PATIENT IS A MINOR:
PARENT/GUARDIAN NAME: ____

RELATIONSHIP____ TEL# _______________________________________

EMPLOYER/OCCUPATION NAME ____

DATE OF BIRTH ________/________/___________ SOC. SEC. #__________-________-______________

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? YES □ NO □

NAME OF INSURED: _____________________________________ INSURED DOB: ____________ INSURED SSN or ID# _______________________

NAME OF INSURANCE COMPANY____ TEL #______________________________

POLICY/GROUP# ____ LOCAL # ____

DO YOU HAVE A SECOND DENTAL INSURANCE? YES □ NO □

NAME OF INSURED: _____________________________________ INSURED DOB: _____________ INSURED SSN # ________-_______-__________

NAME OF INSURANCE COMPANY____ TEL #______________________________

POLICY/GROUP# ____ LOCAL # ____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

NAME ____ RELATIONSHIP_________________________________

TEL# 1 ____ TEL # 2 ____

NAME ____ RELATIONSHIP_________________________________

TEL# 1 ____ TEL # 2 ____

MEDICAL HISTORY

THESE QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THAT THE TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTHCARE. ***PLEASE ANSWER EACH QUESTION.***

_______________________________________ - ____________________ - ____________________
NAME OF PRIMARY PHYSICIAN CITY PHONE#

HAVE YOU EVER HAD ANY SERIOUS ILLNESS OR OPERATION? YES ☐ NO ☐

IF YES, WHAT ILLNESS, OPERATION OR PROBLEM ____

ARE YOU TAKING ANY DRUGS OR **MEDICINES**? YES ☐ NO ☐

IF YES, PLEASE PRINT ____

ARE YOU SENSITIVE OR **ALLERGIC** TO ANY DRUGS? YES ☐ NO ☐

IF YES, PLEASE NAME: *PENICILLIN* ☐ *TETRACYCLINE* ☐ *ANESTHETIC (NOVOCAIN, ETC.)* ☐ *SULFA DRUGS* ☐ *ASPIRIN* ☐ *CODEINE* ☐

ARE YOU SENSITIVE TO **LATEX**? YES ☐ NO ☐ *OTHER* ____________________________________

HAVE YOU EVER TAKEN PRESCRIPTION MEDICATION FOR WEIGHT LOSS (DIET PILLS) YES ☐ NO ☐

IF YES, DID YOU TAKE ANY OF THE FOLLOWING? FEN-PHEN (FENFLURAMINE-PHENPETMINE) YES ☐ NO ☐
PONDIMINE (FENFLURAMINE) YES ☐ NO ☐
REDUX (DEXFENFLURAMINE) YES ☐ NO ☐

DO YOU WEAR A **CARDIAC** PACEMAKER, OR HAVE YOU HAD **HEART** SURGERY? YES ☐ NO ☐ WHEN ____________________

ARE YOU REQURIED TO TAKE ANY MEDICATION BEFORE YOUR DENTAL VISIT? YES ☐ NO ☐ WHAT ____________________

(**WOMEN**) ARE YOU PREGNANT? YES ☐ NO ☐ IF SO, HOW MANY MONTHS? __________

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE EACH INDIVIDUALLY "YES" OR "NO"):

ANEMIA	Y	N	*HEAD INJURIES*	Y	N	*CEREBRAL PALSY*	Y	N	*EPILEPSY OR SEIZURE*	Y	N
HERPES	Y	N	*HEART FAILURE*	Y	N	*JOINT REPLACEMENT*	Y	N	*ARTIFICAL PROSTHESIS*	Y	N
STROKE	Y	N	*LIVER DISEASE*	Y	N	*NERVOUS DISORDER*	Y	N	*PSYCHIATRIC TREATMENT*	Y	N
ULCERS	Y	N	*SCARLET FEVER*	Y	N	*TUMORS OR GROWTHS*	Y	N	*CONGENITAL HEART DISEASE*	Y	N
DIABETES	Y	N	*HEART AILMENTS*	Y	N	*ALLERGIES OR HIVES*	Y	N	*CHICKEN POX*	Y	N
GLAUCOMA	Y	N	*SINUS TROUBLE*	Y	N	*EXCESSIVE BLEEDING*	Y	N	*X-RAY OR COBALT TREATMENT*	Y	N
ARTHRITIS	Y	N	*BLOOD DISEASE*	Y	N	*ASTHMA*	Y	N	*FAINTING SPELLS*	Y	N
EMPHYSEMA	Y	N	*DRUG ADDICTION*	Y	N	*HIGH BLOOD PRESSURE*	Y	N	*CHEMOTHERAPY (CANCER)*	Y	N
HAYFEVER	Y	N	*KIDNEY DISEASE*	Y	N	*AIDS RELATED COMPLEX*	Y	N	*RADIATION TREATMENT*	Y	N
TONSILLITIS	Y	N	*ANGINA PECTORIS*	Y	N	*RESPIRATORY DISEASE*	Y	N	*HEPATITIS OR JAUNDICE*	Y	N
HEMOPHILIA	Y	N	*RHEUMATIC FEVER*	Y	N	*SICKLE CELL DISEASE*	Y	N	*VENEREAL DISEASE*	Y	N
HEART MURMUR	Y	N	*THYROID DISEASE*	Y	N	*TUBERCULOSIS (TB)*	Y	N	*OTHER* ______________		

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM **NOT LISTED ABOVE** THAT YOU THINK WE SHOULD KNOW ABOUT?

YES ☐ NO ☐ IF YES, WHAT? ____

DENTAL HISTORY

____________________ - __________ - ____________________ - __________
NAME OF PREVIOUS DENTIST CITY TELPHONE# DATE OF LAST VISIT

PLEASE LIST ANY PREVIOUS DENTAL EXPERIENCES OR PROBLEMS YOU WOULD LIKE THE DOCTOR TO BE AWARE OF

PLEASE EXPLAIN____

DOES DENTAL TREATMENT MAKE YOU NERVOUS? SLIGHTLY ☐ MODERATELY ☐ EXTERMELY ☐ NO ☐

THE INFORMATION, HEALTH HISTORY AND THE ANSWERS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE CONSENT TO PREFORM DENTAL SERVICES AGREED BETWEEN DOCTOR AND PATIENT AND/OR GUARDIAN TO BE NECESSARY OR ADVISABLE, INCULUDING THE USE OF LOCAL ANESTHESIA AND OTHER MEDICATIONS AS INDICATED. I AGREE THAT, REGARDLESS OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED. IF I EVER HAVE ANY CHANGES IN MY HEALTH OR MEDACATIONS, I WILL, WITHOUT FAIL, INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

SIGNATURE: ____________________________________ **DATE**: ____________________

YEAR 2: DATE:
HEALTH INFORMATION UPDATED ____________ SIGN: ____________________
YEAR 3: DATE:
HEALTH INFORMATION UPDATED ____________ SIGN ____________________
YEAR 4: DATE:
HEALTH INFORMATION UPDATED ____________ SIGN: ____________________
YEAR 5: DATE:
HEALTH INFORMATION UPDATED ____________ SIGN ____________________

OFFICE USE ONLY
YEAR 1 INITIALS______________DATE: ______________
YEAR 2 INITIALS______________ DATE: ______________
YEAR 3 INITIALS______________DATE: ______________
YEAR 4 INITIALS______________ DATE: ______________
YEAR 5 INITIALS______________DATE: ______________