



Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date: _____

Patient Information:

Name _____ Birth Date ____/____/____ Social Security # _____ - _____ - _____

Address _____ City/State/Zip _____

Home Phone(____) _____ Work Phone(____) _____ ext. _____ Cell(____) _____

Sex: Male Female (Circle One) Marital Status: Married Single Divorced Widowed Partnered (Circle One)

Email: _____ Would you like to receive correspondence via email? () YES () NO

Student Status: () Full Time () Part Time Name of School: _____

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

Responsible Party:

Person Responsible for Account _____ Relation to patient: Self Spouse Child Other

Birth date ____/____/____ Social Security # _____ - _____ - _____ Date Employed _____

Address _____ City/State/Zip _____

Home Phone (____) _____ Work Phone (____) _____ ext. _____ Cell (____) _____

Email: _____ Drivers License# _____

Primary Insurance Information:

Name of Insured: _____

Relation to patient: Self Spouse Child Other

Insured SS # _____ - _____ - _____

Insured Birth date ____/____/____

Employer: _____

Insurance Company: _____

Employer Address: _____

Insurance Address: _____

City/State/Zip: _____

City/State/Zip: _____

Secondary Insurance Information:

Name of Insured: _____

Relation to patient: Self Spouse Child Other

Insured SS # _____ - _____ - _____

Insured Birth date ____/____/____

Employer: _____

Insurance Company: _____

Employer Address: _____

Insurance Address: _____

City/State/Zip: _____

City/State/Zip: _____

Dental History:

Reason for today's visit: _____

Date of last dental visit: _____

Former Dentist: _____

Date of last dental x-rays: _____

Circle if you have had problems with any of the following:

Bad Breath

Sensitivity to hot

Sensitivity to cold

Bleeding Gums

Sensitivity to sweets

Sensitivity when biting

Clicking or popping jaw

Sores or growths in your mouth

Periodontal treatment

Food collection between teeth

Grinding Teeth

Loose teeth or broken fillings

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering that following questions.

- Are you under a physician's care now? () Yes () NO If yes, please explain _____
- Have you ever been hospitalized or had a major operation? () Yes () NO If yes, please explain _____
- Have you ever had a serious head or neck injury? () Yes () NO If yes, please explain _____
- Are you taking any medications, pills, or drugs? () Yes () NO If yes, please explain _____
- Do you take, or have you taken, Phen-Fen or Redux? () Yes () NO _____
- Are you on a special diet? () Yes () NO _____
- Do you use tobacco? () Yes () NO _____
- Do you use controlled substances? () Yes () NO _____

Women: Are you:

- Pregnant/Trying to get pregnant? () Yes () NO Taking oral contraceptives? () Yes () NO Nursing? () Yes () NO

Are you allergic to any of the following?

- () Aspirin () Penicillin () Codeine () Acrylic () Metal () Latex () Local Anesthetics
- () Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | |
|---|--------------------------------------|--------------------------------------|---|
| AIDS/HIV Positive () Yes () No | Cortisone Medicine () Yes () No | Hemophilia () Yes () No | Renal Dialysis () Yes () No |
| Alzheimer's Disease () Yes () No | Diabetes () Yes () No | Hepatitis A () Yes () No | Rheumatic Fever () Yes () No |
| Anaphylaxis () Yes () No | Drug Addiction () Yes () No | Hepatitis B or C () Yes () No | Rheumatism () Yes () No |
| Anemia () Yes () No | Easily Winded () Yes () No | Herpes () Yes () No | Scarlet Fever () Yes () No |
| Angina () Yes () No | Emphysema () Yes () No | High Blood Pressure () Yes () No | Shingles () Yes () No |
| Arthritis/Gout () Yes () No | Epilepsy or Seizures () Yes () No | Hives/ Rash () Yes () No | Sickle Cell Disease () Yes () No |
| Artificial Joint () Yes () No | Excessive Bleeding () Yes () No | Hypoglycemia () Yes () No | Sinus Trouble () Yes () No |
| Artificial Heart Valve () Yes () No | Excessive Thirst () Yes () No | Irregular Heartbeat () Yes () No | Spina Bifida () Yes () No |
| Asthma () Yes () No | Fainting/Dizziness () Yes () No | Kidney Problems () Yes () No | Stomach/Intestinal Disease () Yes () No |
| Blood Disease () Yes () No | Frequent Cough () Yes () No | Leukemia () Yes () No | Stroke () Yes () No |
| Blood Transfusion () Yes () No | Frequent Diarrhea () Yes () No | Liver Disease () Yes () No | Swelling Of Limbs () Yes () No |
| Breathing problems () Yes () No | Frequent Headaches () Yes () No | Low Blood Pressure () Yes () No | Thyroid Disease () Yes () No |
| Bruise Easily () Yes () No | Genital Herpes () Yes () No | Lung Disease () Yes () No | Tonsillitis () Yes () No |
| Cancer () Yes () No | Glaucoma () Yes () No | Mitral Valve Prolapse () Yes () No | Tuberculosis () Yes () No |
| Chemotherapy () Yes () No | Hay Fever () Yes () No | Pain in Jaw Joints () Yes () No | Tumors or Growths () Yes () No |
| Chest Pains () Yes () No | Heart Attack/Failure () Yes () No | Parathyroid Disease () Yes () No | Ulcers () Yes () No |
| Cold Sores/Fever Blisters () Yes () No | Heart Murmur () Yes () No | Psychiatric Care () Yes () No | Venereal Disease () Yes () No |
| Congenital Heart Disorders () Yes () No | Heart Pace Maker () Yes () No | Radiation Treatment () Yes () No | Yellow Jaundice () Yes () No |
| Convulsions () Yes () No | Heart Trouble/Disease () Yes () No | Recent Weight Loss () Yes () No | |

Have you ever had any serious illness not listed above? () Yes () No If yes, please explain: _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company (iss)

Dr. Jessica Nieva all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Jessica Nieva may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian _____ Date _____

Print Name of Patient, Parent, Guardian _____ Relationship to Patient _____