Boulder Creek Dental Office
Big Basin Hwy at Oak
Boulder Creek, CA 95006

Patient's Name ______________________ Birthdate ____________

Name of Primary Physician			Date of Last Physical
Address of Physician	City	ZIP	Phone

Have you been hospitalized or had any serious illness during the past 5 years? ☐ Yes ☐ No

Have there been any changes in your health during the last year? ☐ Yes ☐ No

If so, what? ______________________

What is your blood pressure? ____________

Have You Ever Had Any of the Following: Check Yes or No

Yes	No	
☐	☐	Pace Maker
☐	☐	Rheumatic Fever
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Attack
☐	☐	Angina
☐	☐	Mitral Valve Prolapse
☐	☐	Stroke
☐	☐	Clotting (Bleeding) Problems
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Blood Transfusion
☐	☐	Hepatitus
☐	☐	Venereal disease (Syphilis, Gonorrhea)

Yes	No	
☐	☐	A.I.D.S. or HIV Test Positive
☐	☐	Kidney or Bladder Disease
☐	☐	Diabetes
☐	☐	Epilepsy or Seizures
☐	☐	Fainting or Dizzy Spells
☐	☐	Glaucoma
☐	☐	Sinus Trouble
☐	☐	Thyroid Disease
☐	☐	Radiation or Cobalt Treatment
☐	☐	Alcoholism/ Chemical Dependency
☐	☐	Mental Disorders

Yes	No	
☐	☐	Bi-sulfite reaction (food preservative)
☐	☐	Prosthetic (Artificial Joint - i.e. knee or hip replacement)
☐	☐	Ulcers
☐	☐	Tuberculosis
☐	☐	Chronic Lung Problems, or Emphysema
☐	☐	Cancer/Tumor
☐	☐	Anemia
☐	☐	Arthritis/Rheumatism

Do you have any allergies or problems with any medications or drugs you have taken? ☐ Yes ☐ No

If yes, please explain ______________________

Are you taking any medications or drugs at this time? ☐ Yes ☐ No

If yes, which and how often? ______________________

Are you taking?

☐ Yes ☐ No Recreational Drugs? ☐ Yes ☐ No Alcohol? Do you wear contact lenses? ☐ Yes ☐ No

☐ Yes ☐ No Tobacco in any form?

WOMEN ONLY

☐ Yes ☐ No Are you or could you be pregnant or nursing?

☐ Yes ☐ No Taking birth control pills?

ALL PATIENTS: Do you have or have had any other diseases or medical problems not listed on this form? ☐ Yes ☐ No

If so, please explain ______________________

Are you happy with the appearance of your smile? ☐ Yes ☐ No

If not, please explain ______________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature ______________________ Date ____________

Recall Review:

Patient's Initials	Date	Patient's Initials	Date
Patient's Initials	Date	Patient's Initials	Date
Patient's Initials	Date	Patient's Initials	Date

Dental Office Registration Form

Date ________________

Patient Information:

Circle One Mr. Mrs. Ms. Dr.	Patient First Name	Middle Initial	Last Name	Preferred First Name

Physical Street Address	City	Zip
Mailing Address	City	Zip

Home Phone	Work Phone	Cell Phone	Alternate Phone

Date of Birth	Social Security Number	Driver License Number

Employed By	How Long	Present Position

Address of Employer	City	State	Zip

Marital Status Single Divorced Widow Married	Emergency Contact	Emergency Phone

Spouse Information:

Circle One Mr. Mrs. Ms. Dr.	Spouse First Name	Middle Initial	Last Name	Preferred First Name

Address, If Different Than Patient	City	Zip

Home Phone	Cell Phone	Employed By	Work Phone

Person Responsible For Account:

First Name	Middle Initial	Last Name	Relationship To Patient

Address, If Different Than Patient	City	Zip

Home Phone	Cell Phone	Employed By	Work Phone

Date of Birth	Social Security No.	Drivers License No.

Dental Insurance Information:

Dental Insurance Carrier	Insurance Company Phone	Group #	Phone	How Long Covered

Name of Person Carrying Insurance, if Other Than Patient	Social Security # of Insured Other Than Patient & Date of Birth

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WHO MAY WE THANK FOR REFERRING YOU? ____

Signature: ____ Date: ____________________

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, etc., which still has to be paid whether you are present or not. Once an appointment is made please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient as per their insurance.

New Patient Dental History

Patient ______________________

Name of Former Dentist			Date of Dental Exam
Address of Former Dentist	**City**	**ZIP**	**Phone**

May we send for your dental records? . . . . Yes No

Have you had any major dental treatment during the past five years?. . . . . Yes No

If so, what? ______________________

Are you aware of any changes in your dental health during the last year?. . . . . Yes No

If so, what? ______________________

What is the primary reason for your visit? ______________________

Please explain: ______________________

What did you **like** about your previous dentist? ______________________

What did you **not like** about your previous dentist? ______________________

What is your major concern in regard to your dental treatment? ______________________

How many times during the day do you brush your teeth? __________ Floss your teeth? __________

Have You Ever Had Any of the Following:

Orthodontics, Oral Surgery, Periodontal Surgery, Bleeding Gums, Itching Gums

If so, please explain: ______________________

Do You Have Any of the Following:

Bleeding Gums, Itching Gums, Dry Mouth, Unpleasant Taste,
Pain on Chewing, Sensitivity to Hot, Cold, Air, Clenching or Grinding

If so, please explain: ______________________

Have you ever been involved in litigation as a result of a medical or dental situation? . . . . Yes No

Do you have problems in becoming numb from dental anesthetic? . . . . Yes No

If so, please explain: ______________________

Are you happy with the appearance of your smile? . . . . Yes No

If not, please explain: ______________________

Patient Signature: ______________________ Date: ______________________