REDLANDS TOWN DENTAL
Brenda Miller, DDS,APC 10010 Alabama St. Ste A Redlands CA 92374 (909)335-0025

PATIENT INFORMATION

Patient Name: _____ (Last / First / M) Email address: _____ Date: _____

Address: _____ (Street / Apt. # / City / State / Zip)

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____ Cellular/Pager: _____

Height: _____ Weight: _____ Sex: ☐ M ☐ F Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated

If Student, _____ (Name of School/College / City / State / Grade) ☐ Full Time ☐ Part Time

Patient's Employer: _____ Occupation: _____ SS#: _____

Business Address: _____ (Street / Suite # / City / State / Zip)

Spouse Name: _____ Employer: _____ Work Phone: _____

Person to contact in case of emergency: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

Who reffered you to us? Or how did you hear about us? _____

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address (if different from above): _____ (Street / Apt. # / City / State / Zip)

Birthdate: ___/___/___ Telephone: Home: _____ Work: _____

SS #: _____ Driver's License #: _____

Primary Dental Coverage Information

If you do NOT have primary coverage, please check this box: ☐

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

Secondary Dental Coverage Information

If you do NOT have secondary coverage, please check this box: ☐

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Address (if different from above): _____ City: _____ State: ____ Zip: _____

SS #: _____ Driver's License #: _____ Date Employed: _____

Name of Employer: _____ Union or Local #: _____ Telephone: Work: _____ Home: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Dental Ins. Company: _____ Group #: _____ Policy/ID #: _____

DENTAL HISTORY

Please answer each question by circling Yes or No.

Do you have a specific dental problem or chief complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? Describe: _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ 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 been positive? _____ Yes No

Name of previous dentist: _____ Date of last full mouth x-ray series: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____

(If patient is a minor, include printed name and signature of parent or legal guardian)

DO NOT WRITE IN THIS SPACE

DATE: REVIEWED BY: DENTIST'S COMMENTS: _____

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HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? ..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
   If yes, what is the condition being treated? _____
   Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? ..... Yes No
   Please explain: _____
5. Are you taking any medication? ..... Yes No
   If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? ..... Yes No
   If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin
   ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other If Other, please list: _____ ..... Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

☐Y ☐N AIDS	☐Y ☐N Cortisone Medicine	☐Y ☐N Hemophilia	☐Y ☐N Respiratory Disease
☐Y ☐N Allergies or Hives	☐Y ☐N Diabetes	☐Y ☐N Hepatitis or Jaundice	☐Y ☐N Rheumatic Fever
☐Y ☐N Allergies to Metals	☐Y ☐N Difficulty in Swallowing	☐Y ☐N Herpes	☐Y ☐N Rheumatism
☐Y ☐N Anemia	☐Y ☐N Drug Addiction	☐Y ☐N High Blood Pressure	☐Y ☐N Sickle Cell Disease
☐Y ☐N Angina Pectoris	☐Y ☐N Emphysema	☐Y ☐N HIV Positive	☐Y ☐N Sinus Trouble
☐Y ☐N Arthritis	☐Y ☐N Epilepsy or Seizures	☐Y ☐N Joint Replacement	☐Y ☐N Stomach Ulcers
☐Y ☐N Artificial Heart Valve	☐Y ☐N Excessive Bleeding	☐Y ☐N Kidney Disease	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Fainting Spells or Seizures	☐Y ☐N Liver Disease	☐Y ☐N TMJ
☐Y ☐N Blood Disease	☐Y ☐N Glaucoma	☐Y ☐N Mental Disorder	☐Y ☐N Thyroid Disease
☐Y ☐N Blood Transfusion	☐Y ☐N Hay Fever	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Tonsillitis
☐Y ☐N Bruise Easily	☐Y ☐N Head Injuries	☐Y ☐N Nervous Disorders	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	☐Y ☐N Heart Ailments or Attack	☐Y ☐N Pain in Jaw Joints	☐Y ☐N Tumors or Growths
☐Y ☐N Cold Sores	☐Y ☐N Heart Failure	☐Y ☐N Psychiatric Treatment	☐Y ☐N Venereal Disease
☐Y ☐N Congenital Heart Lesions	☐Y ☐N Heart Murmur	☐Y ☐N Radiation Treatment	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ ..... Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other ..... Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ ..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? or Bisphosphonates? ..... Yes No
14. Are you pregnant? If yes, how many months? _____ ..... N/A Yes No
15. Do you have any problems associated with your menstrual period? ..... N/A Yes No
16. Do you take birth control pills? ..... N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ..... Yes No
    Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

3rd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1st		/			
2nd		/			
3rd		/			