Carol L. Daderian, D.D.S.
32272-C Camino Capistrano San Juan Capistrano, Ca. 92675 (949) 661-3594

The following confidential information is for our records only:

Patient Information

Patient's Name ________________________________ Birth Date ______________ Male / Female
First Middle Last

Address ______________________________ City __________________ State _____ Zip Code ______

Home Phone ____________ Cell Phone____________ Social Security _____________ Driver's License _________

Employer ______________________________________ Business Phone ______________________

Business Address ________________________ City __________________ State _____ Zip Code _____

Emergency Contact ______________________________________ Phone ____________________

Email ____________________________ How were you referred to this office? ____________________

Responsible Party

Name ________________________________ Name of Spouse ______________________________
First Middle Last

Address (if different) ________________________ City __________________ State _____ Zip Code _____

Home Phone __________________ Social Security # ________________ Driver's License # __________

Employer ______________________________________ Business Phone ______________________

Business Address ________________________ City __________________ State _____ Zip Code _____

Relationship to Patient ____________________________

Insurance Information

Do you have dental insurance? Yes _____ No _____

Insurance Company Name ________________________________ Group # ____________________

Insurance Address ____

Insured's Name ______________________________ Insured's Birthdate ______________________

Insured's ID # ________________________________

I understand my dental insurance is a contract between my insurance company and me. Any amount not paid by my insurance company is due and payable by me.

Signature ____ Date ______________________

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NAME ______________________________ DATE OF BIRTH ____________________

HEALTH HISTORY

Are you in good health? .... Yes ___ No ___
Are you having dental pain or discomfort at this time?.......... ....Yes_____ No_____
Have you been a patient in the hospital during the last two years?...................... Yes ___ No ___
If so, what for? ______________________________
Are you under the care of a physician? Yes____No___Name______________________
Physcian Telephone #______________If so, what are you being treated for? ____________________
Are you now taking any medications or over-the-counter drugs or herbs?.........................Yes ___ No ___
If so, please list: ______________________________
Are you sensitive or allergic to any medications or anesthetics?...........................Yes ___ No ___
If so, please list: ______________________________
Have you had problems with prior dental treatments?..Yes ___ No ___
If so, what happened? ______________________________
Have you ever taken Bisphosphonates, such as Fosamax or ReClast?...Yes ___ No ___
If yes, when? ______________________________
Have you been exposed to the HIV virus or AIDS?...Yes ___ No ___
Have you ever had gum treatment/surgery?..Yes ___ No ___
If yes, when? ______________________________
Please list any other diseases or medical problems not listed on this form ____________________
____
For women: Are you pregnant?..Yes___ No ___
If yes, what month? ____________________
For women: Are you taking birth control pills?..Yes ___ No ___
For women: Have you reached menopause?...Yes ___ No ___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...

	Yes	No
Rheumatic fever		
Heart Disease		
Heart Attack		
Mitral Valve Prolapse or Prosthetic Valve		
Heart murmur or irregular beat		
Cardiac pacemaker		
High/Low blood pressure		
Hepatitis A, B, or C		
Artificial joints (hip, knee, etc.)		
Stroke		
Cancer		
Radiation or Chemotherapy		
Dialysis		
Emphysema		
Asthma		
Tuberculosis		
Cold sores/Fever blisters		
Contagious or viral diseases		
Sexually Transmitted Diseases		
Blood transfusion		
Anemia or other blood disorder		
Hypoglycemia or low blood sugar		
Bleed easily		

	Yes	No
Diabetes		
Parkinson's or other systemtic disease		
Alzheimer's		
Developmentally disabled		
Thyroid problems		
Kidney problems		
HIV//AIDS		
Allergies/Hay fever/Sinus problems		
Ulcers or acid reflux		
Glaucoma or other eye disease		
Chronic fatigue		
Bronchitis/Chronic cough/Pneumonia		
Headaches		
Epilepsy/Seizures		
Dizzy spells/Fainting		
Mental health problems/anxiety/depress		
Allergy to latex		
Drug or Alcohol addiction		
Smoke, Vape, or chew		
Removable dental appliance		
Pain/Clicking of jaw		
Bruise easily		
Supplements or herbs		

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NAME ____

Patient Complaint: Please indicate all that apply:

Clench or grind teeth ______________________
Bleeding gums ______________________
Bad taste or breath odor ______________________
Tooth sensitivity to hot, cold, bite or sweet ______________________
Loose teeth ______________________
Other ______________________
Orthodontic treatment currently or in the past ______________________
How long since your last full mouth set of x-rays? ______________________
How long since your last dental treatment? ______________________

CONSENT

* I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
* I have answered all questions truthfully and to the best of my knowledge.
* The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
* I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ______________________.
* I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
* I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.
* I also understand it is my responsibility to know and understand my dental benefits, and not the responsibility of the dental office.
* In the event payments are not received by the agreed upon dates, I understand that a 1.5 % finance charge (18% APR) may be added to my account, in addition to any collection charges.
* I understand that it is my responsibility to advise your office of any changes in the information contained on the form, including the previous pages.

Signature ____ **Date** ______________________

HEALTH HISTORY UPDATES

Signature ______________________ Date ____________ Signature ______________________ Date ____________

Signature ______________________ Date ____________ Signature ______________________ Date ____________

Signature ______________________ Date ____________ Signature ______________________ Date ____________

Signature ______________________ Date ____________ Signature ______________________ Date ____________

Signature ______________________ Date ____________ Signature ______________________ Date ____________