Santa Fe Dental Group

P. (760)732-5878 F. (760)732-5939
1234 N Santa Fe Ave Suite 114
Vista, Ca 92083
TheVistaDentist.com

CONFIDENTIAL PATIENT INFORMATION

Please Print Clearly

Date: _____
Chart: _____

L Patient Information

Name: _____ Birthdate: _____ Gender: _____
Address: _____ City & State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ E-mail: _____
Social Security #: _____ Driver's License #_____
Employer's Name: _____ Work Number: _____

II. Responsible Party

Name:_____Birthdate: _____Relationship to Patient:_____
Social Security #:_____-_____-_____ Name of Employer:_____ Phone # :(_____)_____
Address:_____ City: _____ Zip Code:_____
Name of Insurance Company:_____ Phone#: _(_____)_____
Insurance I.D. #_____Group Number:_____

III. Second insurance Information (Complete this section if patient is covered by another insurance company)

Name:_____Birthdate: _____Relationship to Patient:_____
Social Security #:_____-_____-_____ Name of Employer:_____ Phone # :(_____)_____
Address:_____ City: _____ Zip Code:_____
Name of Insurance Company:_____ Phone#: _(_____)_____
Insurance I.D. #_____Group Number:_____

IV. Getting To Know You and Your Family

How did you hear about Santa Fe Dental Group? _____
Last dental x-rays taken? _____
When was your last dental visit? _____
What treatment was performed? _____

Please list all immediate family members:

Name:	Relationship:	Birthdate	Date of last dental visit

IV. Emergency Contact (Friend or relative not living with you)

Name: _____Telephone: _(_____)_____

So we may bill your insurance directly, please sign.

I HAVE RECEIVED THE DIRECTIONS TO ACCESS HIPAA NOTICE FROM THE WEBSITE: WWW.THEVISTADENTIST.COM

I hereby authorize payment directly to Santa Fe Dental Group of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize dental care and release of any information relating to this claim.

_____ (Signature of Insured)

We Make Smiles Happen!

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MEDICAL HISTORY

Patient's Name:_____ Age:_____ Chart #: _____ Date : _____

1. Is patient in good health? ☐Yes ☐ No If no, explain_____
2. Physicians name:_____ Phone Number: _____
   Is patient under physicians care now? ☐Yes ☐ No If yes, explain_____
3. Is patient taking prescribed or any over the counter medication? Birth control medications?.....☐Yes☐ No
   If yes list medications:_____
4. Is the patient pregnant? ☐Yes ☐ No.. If so, how many months?_____Nursing mother?.....☐Yes☐ No
5. Has patient taken any weight loss medication? (e.g. PhenFen).....☐Yes☐ No
6. Has patient ever had a blood transfusion?.....☐Yes☐ No
7. Does the patient smoke? ☐Yes ☐ No Use tobacco? ☐Yes ☐ No Use recreational drugs?.....☐Yes☐ No
8. Does the patient use alcohol? ☐Yes ☐ No If yes, how often?_____
9. Has the patient ever had an allergic reaction to local anesthetic (e.g. Novocain).....☐Yes☐ No
10. Is the patient allergic to any medications? (e.g. penicillin)?.....☐Yes☐ No
11. Has the patient ever had an allergic reactions to metals or jewelry.....☐Yes☐ No
12. Is the patient allergic to latex?.....☐Yes☐ No
13. Has the patient ever had prolonged bleeding after an injury or extraction.....☐Yes☐ No
14. Does the patient have a cardiac pacemaker or artificial heart valve?.....☐Yes☐ No
15. Is there any family history of diabetes, heart murmur/ problems, cancer/tumors?.....☐Yes☐ No
16. Does the patients jaw pop or click when chewing? (TMJ).....☐Yes☐ No
17. Are you pleased with the appearance of your smile?.....☐Yes☐ No
    If no, explain
18. What would you like to discuss with your dentist today?

☐Tooth ache	☐oral surgery	☐partials/dentures	☐cosmetic dentistry
☐Gum problems	☐routine checkups	☐removal or wisdom teeth	☐crowns and bridges
☐Braces	☐second opinion	☐replace missing teeth	☐other_____

19. Does the patient have any missing teeth? ☐ Yes☐ No if yes, does the patient have an appliance?..... ☐Yes ☐ No
    What type?_____ Year made?_____ Is it comfortable?..... ☐Yes ☐ No
20. Please check each box, yes or no, if the patient has ever had any illness or condition listed below. Please do not leave blank.

Y N		Y N		Y N		Y N	
☐ ☐	AIDS/HIV	☐ ☐	Allergies	☐ ☐	Anemia	☐ ☐	Angina
☐ ☐	Arthritis	☐ ☐	Artificial Joint	☐ ☐	Asthma	☐ ☐	Bleeding Disorder
☐ ☐	Cancer	☐ ☐	ChemoTherapy	☐ ☐	Cold Sores	☐ ☐	Diabetes
☐ ☐	Dizzy spell	☐ ☐	Emphysema	☐ ☐	Epilepsy	☐ ☐	Emotional disorder
☐ ☐	Fainting	☐ ☐	Fever Blister	☐ ☐	Glaucoma	☐ ☐	Heart attack
☐ ☐	Heart bypass	☐ ☐	Heart murmur	☐ ☐	Heart problems	☐ ☐	Heart surgeries
☐ ☐	Hepatitis	☐ ☐	High blood pressure	☐ ☐	HIV positive	☐ ☐	Immunosuppresed
☐ ☐	Jaundice	☐ ☐	Kidney disease	☐ ☐	liver Problem	☐ ☐	Low blood pressure
☐ ☐	Lung Disease	☐ ☐	Nervous/mental disorder	☐ ☐	psychiatric treatment	☐ ☐	Cancer radiation Therapy
☐ ☐	Rheumatic Fever	☐ ☐	Sinus trouble	☐ ☐	stroke	☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis	☐ ☐	Venereal Disease				

21. Has patient had any disease, serious illness/ surgery condition or problems not listed above? ☐Yes ☐ No Explain_____
22. Has patient been on any IV Bisphosphonates or Oral Bisphophonates in the last 5 years? ☐Yes ☐ No 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. I further certify that I consent to the performing of x-rays and oral examination.

_____ _____

Patients signature/responsible party if patient is minor Date

For Doctors use only

Health History Reviewed by_____ Date _____ Comments:_____
Recall Review date:_____
Patients Signature_____ Doctors Signature:_____