Welcome to
Heavenly Dental

Patient Information

Name: _____

Address:_____ Apt: _____

City: _____State:_____ Zip: _____

Phone:(_____)_____ Cell: (_____)_____

SSN:_____Date of Birt: _____

E-Mail:_____

Responsible Party (if applicable)

Name: _____

Address:_____ Apt: _____

City: _____State:_____ Zip: _____

Phone:(_____)_____ Cell: (_____)_____

SSN:_____Date of Birt: _____

E-Mail:_____

Employment Patient Responsible Party

Employer: _____

Occupation:_____ How Long?_____

Business Address: _____

City: _____ St: _____ Zip: _____

Business #: (_____)_____ Ex: _____

Emergency Contact

Name: _____

Address:_____ Apt: _____

City: _____State:_____ Zip: _____

Phone:(_____)_____ Cell: (_____)_____

Relationship to patient:_____

Physician Name:_____ Phone: _____

Insurance Coverage(check one)

❒Denti-Cal ❒HMO ❒PPO ❒Indemnity ❒Other _____

Insured Party Information Only (if applicable)

Name: _____Address:_____

City: _____State: _____ Zip: _____

SSN:_____ Date of Birt: _____

Employer: _____ Union/Local:_____

Policy/ Group #_____ Insurance ID # _____

Primary Insurance Company:_____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Secondary Insurance Company:_____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insured's Name:_____Insured's SSN:_____

Insured's Date of Birth: _____ Insured's Employer:_____

Union/ Local _____ Policy/ Group # _____

How did you here about us?

❒ Flyer/Ad ❒ Insurance Plan Referral ❒ 1-800-Dentist

❒Sign/Building ❒Marketing Representative, where: _____

❒Yellow Pages ❒Employer ❒Other DDS Referral ❒Family ❒Friend

❒Website ❒Other ❒Penny Saver ❒Other _____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

Signature of Responsible Party_____ Date _____

(Parent/Legal Guardian if patient is a minor)

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comment

Heavenly Dental **HEALTH HISTORY** **CHART NO.**_____

HISTORIA DE SALUD

PATIENT NAME(NOMBRE) _____ DATE(FECHA) _____

DATE OF BIRTH (FECHA DE NACIMIENTO)_____ SEX (SEXO): M/ F HEIGHT (ESTATURA)_____ WEIGHT (PESO LBS)____

Answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be strictly confidential.

Conteste todas las preguntas y llene los espacios en blanco cuando Se mpliqué. Las contestaciones a nuestras preguntas son unicarnente para nuestras archivos, y se consideran confidencial.

		Yes	No
1	Are you in good health		
2	Has there been any significant change in your general health within the past year My last physical was on		
3	Are you now under the care of a physician If so, what is the condition being treated _____ The name and Tel. of my physician is _____ Please list any medications you are taking _____ _____ _____		
4	Have you been hospitalized from a serious illness or operation within the last 5 years. If so, explain		
5	Do you have or have you had any of the following diseases or problems: **A** High or Low Blood Pressure ..... **B** Heart Conditions: Damaged/ ..... Artificialheartvalves, cardiovascular disease, murmurs, coronary insufficiency/occlusion, stroke, heart lesions or Mitral Valve Prolapse • Do you have pain in chest upon exertion ..... • Are you ever short of breath after mild exercise • Do your ankles swell ..... • Do you get short of breath when you lie down, or do you require extra pillows when you sleep. **C** Do you have a cardiac pacemaker ..... **D** Do you have Rheumatic Fever/Heart Disease..... • Sinus trouble ..... **E** Asthma ..... **F** Hives or skin rash ..... **G** Fainting spells or seizures ..... **H** Diabetes ..... • Do you have to urinate (pass water) more than 6 times a day ..... • Are you thirsty much of the time ..... **I** Hepatitis, jaundice or liver disease ..... • Arthritis ..... • Inflammatory rheumatism (swollen joints) ..... **J** Stomach ulcers ..... **K** Kidney trouble ..... **L** Tuberculosis ..... **M** Anemia ..... **N** A persistent cough or cough up blood ..... • Do you have prosthetic hip or joint prosthesis, implants, bone plates or pins ..... If so, what		
6	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... • Do you bruise easily ..... • Have you ever required a blood transfusion ..... if so, explain		
7	Have you ever taken Phen-fen		
8	Do you drink Alcoholic Beverages		

		Si	No
1	Esta usted en buen salud		
2	Ha habido cambio de su salud durante el ultimo año pasado Mi ultimo examen medico fue en		
3	Esta ahora bajo atencion medica Si es asi, que enfermedad se esta curando _____ El nombre y # de telefono de mi medico es _____ Porfavor detalle cualquier medicamientos que esta tomando: _____ _____ _____		
4	Ha estado hospitaliizado de una enfermedad seria o operacion dentro los ultimos 5 anos. Si es asi, explique		
5	Tiene o ha tenido alguna de las siguientes enfermedades o problemas: **A** Alta o Baja presion arterial (sangre)..... **B** Enfermedad del Corazon: Valvulas artificiales o danadas, insuficiencia cardiaca, oclusion coronaria, arteriosclerosis, sincope, LesiOn cardiaca a Mitral Válvula Prolapse ..... • Tiene dolor en el pecho cuando hace esfuerzo ..... • Le falta el aire despues de hacer algun ejercicio • Se le hinchan los tobillos ..... • Cuando se acuesta, le falta aire para respirar o le faltan mas almohadas para dormir ..... **C** Tiene un marcapasos cardiaco ..... **D** Fiebre/InfecciOn reumática del corazon ..... • Problema de senusitis ..... **E** Asma ..... **F** Ronchas a sarpullido ..... **G** Desmayos y sudores a ataques ..... **H** Diabetis ..... • Orina usted mas de seis veces por dia ..... • Tiene sed la mayoria del tiempo ..... **I** Hepatitis, ictericia o enfermedad del higado • Artritis ..... • Inflarnacion reumatica (coyunturas inflamades) **J** Ulceras estomacales ..... **K** Enfermedad del rinon ..... **L** Turberculosis ..... **M** Anemia ..... **N** Tos persistente O tos con sangre ..... • Tiene cadera o conjuntura prosthetica, implantes placa de hueso or tornillos ..... Si es asi, que		
6	Ha sangrado anormalmente, cuando una extraccion dental, Cirujia o trauma ..... • Se moretea su piel facilmente ..... • Harequerido transfusion de sangre ..... siesasi,explique		
7	Ha tomado usted Phen-fen		
8	Usted toma tragos alcohOlicos		

		Yes	No
09	Do you Smoke If so, how much		
10	Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or		
11	Are you taking any of the following: **A** Antibiotics or sulfa drugs **B** Anticoagulants (blood thinners) If so, what **C** Medicine for high blood pressure **D** Cortisone (steroids) **E** Tranquilizers **F** Antihistamine **G** Insulin, tolbutamide (orinase) or similar drug **H** Digitalis or drugs for heart trouble **I** Nitroglycerin **J** Oral contraceptive or other hormonal therapy		
12	Are you allergic or have you reacted adversely to: **A** Local anesthetics **B** Penicillin or other antibiotics **C** Barbiturates, sedatives or sleeping pills **D** Aspirin or Sulfa Drugs **E** Iodine **F** Codeine or other narcotics **G** Latex or rubber products **H** Other		
13	Have you had any problems or serious trouble associated with any previous dental treatment If so, explain		
14	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation		
15	Do you have, or have you had personal contact with anyone who has the following (please circle): **A** Herpes **B** Hepatitis **C** TB **D** AIDS **E** Venereal Disease **F** HIV		
16	Are you pregnant or think you might be		
17	Are you nursing		
18	Do you have any other medical, mental or physical problem/condition not listed above (Autism, Down's Syndrome, etc.). If so, explain		

		Si	No
09	Usted Fuma Si es cierto, cuanto		
10	Ha tenido cirujia o rayos x para tratar algun tumor, creco, o ortra emfermedad de la boca o labios		
11	Esta tomando los siguientes medicamentos: **A** Sulfamidas o antibioticos **B** Anticoagulantes (aclarar la sangre) Si es asi que **C** Medicamento contra la alta presion **D** Cortisona (esteroide) **E** Tranquilizantes **F** Antihistaminico **G** Insulina, tobultamida o drogas similares **H** Para enfermadades del corazon **I** Nitroglicerina **J** Anticonceptivos orales o otra terapia hormonal		
12	Esta alergico o ha reaccionado adversamente a: **A** Anestesia local **B** Antibioticos o penicilina **C** Barbitürico, sedantes o pastillas para dormir **D** Aspirina or Drogas con sulfas **E** Yodo **F** Codeina o otros narcoticos **G** Latexoproductosdehule **H** Alguna otra		
13	Ha tenido algun problema despues de haber tenido un tratamiento dental Si es asi expligue		
14	Esta trabajando o esta en un situacion donde esta expuesto regularmente a radiografias o algun otra forma de radiacion		
15	Usted tiene o ha estado en contacto personal con alguien con lo siguiente (por favor de circular): **A** Herpes **B** Hepatitis **C** Tuberculosis **D** SIDA **E** Enfermedades Venéreas **F** HVI		
16	Esta usted embarazada o piensa que si		
17	Esta amamantando (dando pecho)		
18	Tiene usted alguna otra enfermedad o condicion no mencionado anteriomente (Autismo, SIndrome de Down, etc.).Si es asi, explique		

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that 1, the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

Yo he leIdo lo de arriba y he contestado este cuestionario de Salud totalmente. He dado a conocer todos los trastornos de que conocimiento. Además certifico que yo, el que firma, presto mi consentimiento para que hagan el uso de rayos X, reexaminación o cualquier tratamiento dental que sea de acuerdo o aconsejado.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____ DATE

FIRMA DEL PACIENTE O REPRESENTANTE LEGAL _____ FECHA

SIGNATURE OF DOCTOR (Firma del Doctor) _____ DATE

***UPDATE TO MEDICAL HISTORY/ ACTUALIZAR* HISTORIA DE SALUD**

DATE/FECHA	COMMENTS/COMENTARIOS	PATIENT SIGNATURE/FIRMA DEL PACIENTE	DR. SIGNATURE

*Update is noting no change in Medical History/ Actualizar Y notar ningun cambio en la Historia De Salud

Medical Clearance Required: YES / NO For: