Mountain View Family Dentistry

569 W El Camino Real Mountain View, CA 94040
(650)-938-9000

Patient Information

Date: _______________ Last Name: _____________________________ First Name: _______________________________

Address: ____ City: ____________________ State: __________ Zip: __________

S.S.N: ________________________ Date of Birth: _____________________ Gender: Male/Female

Email Address: _____________________________________ Home #: _________________ Cell #: ___________________

Employer/School: ____ Occupation: _________________________________

Employer Address: ____________________________ City: ____________________ State: ____________ Zip: ___________

How did you hear about us? _____________________ How long since your last dental visit? _____________

Former Dentist: ___________________ Why are you here today? __________________________

Insurance Information

Primary Insurance Company: _______________________________________ Phone Number: _______________________

Policy Holder: ____________________________ Member ID#/SSN: ______________________ Date of Birth: __________

Secondary Insurance Company: _____________________________________ Phone Number: _______________________

Policy Holder: ____________________________ Member ID#/SSN: ______________________ Date of Birth: __________

Medical History

In case of emergency call: _____________________ Phone #: _____________________ Relationship: _______________

Have you had unfavorable (allergic) reactions to any of the following? Check any of the following that applies to you.

○Aspirin ○Novocain ○Sedative ○Penicillin ○Codeine ○Anesthetics ○Latex Glove

○Amoxicillin ○Phen Phen ○Redux ○Other Drugs: ________________

Please list any drugs taken in the past or currently taking: ____

1. Are you feeling any pain or discomfort at this time? ○Yes ○No
2. Do you feel nervous about having dentistry treatment? ○Yes ○No
3. Have you ever had a bad experience in a dentistry office? ○Yes ○No
4. Have you been a patient in the hospital during the past two years? ○Yes ○No
5. Have you been under the care of a medical doctor during the past two years? ○Yes ○No
6. Have you ever had any excessive bleeding requiring special treatment? ○Yes ○No
7. Have you had any serious trouble associated with any previous ○Yes ○No

dental treatment? If yes, please explain to the best of your knowledge:

____

8. Are you on a special diet? ○Yes ○No
9. Has your medical doctor ever said you have cancer or a tumor? ○Yes ○No
10. Do you have any disease, condition, or problem not listed? ○Yes ○No
If so please explain:

____

11. Women:
Are you pregnant? ○Yes ○No
Are you currently using birth control? ○Yes ○No
Do you anticipate becoming pregnant? ○Yes ○No

12. Check any of the following which you have had or have presently:

Y	N	Heart Failure	Y	N	Emphysema	Y	N	AIDS
Y	N	Heart Disease/Attack	Y	N	Cough	Y	N	Hepatitis A (Infectious)
Y	N	Angina Pectoris	Y	N	Tuberculosis (TP)	Y	N	Hepatitis B (Serum)
Y	N	High Blood Pressure	Y	N	Asthma	Y	N	Liver Disease
Y	N	Heart Murmur	Y	N	Hay Fever	Y	N	Yellow Jaundice
Y	N	Rheumatic Fever	Y	N	Sinus Trouble	Y	N	Blood Transfusion
Y	N	Congenital Heart Lesions	Y	N	Thyroid Disease	Y	N	Hemophilia
Y	N	Scarlett Fever	Y	N	Diabetes	Y	N	Drug Addiction
Y	N	Artificial Heart Valve	Y	N	X-Ray or Cobalt Treatment	Y	N	Cold Sore
Y	N	Heart Surgery	Y	N	Allergies or Hives	Y	N	Genital Herpes
Y	N	Heart Pacemaker	Y	N	Chemotherapy (Cancer, Leukemia)	Y	N	Epilepsy or Seizures
Y	N	Artificial Joint	Y	N	Arthritis	Y	N	Fainting or Dizzy Spells
Y	N	Anemia	Y	N	Rheumatism	Y	N	Anxiety
Y	N	Stroke	Y	N	Cortisone Medicine	Y	N	Psychiatric Treatment
Y	N	Kidney Trouble	Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Ulcers	Y	N	Pain in jaw joints	Y	N	Venereal Disease

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicine changes, I will inform the Doctor of Dentistry at the next appointment without fail.

Signature: ____ Date: __________________________

Reviewed by: ______________________________________ Date: __________________________