OFFICE _____
CHART # _____
REFERRAL CODE _____

ARCADIA DENTAL GROUP

☐ PVT ☐ INS ☐ MC ☐ PP ☐ PLAN
ACCT. TYPE

I. PATIENT INFORMATION

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

WHAT BROUGHT YOU BACK TO OUR OFFICE?

Cell:

E-Mail:

PLEASE PRINT -

Please Check
MARRIED ☐
SINGLE ☐
DIVORCED ☐
WIDOWED ☐
CHILD ☐

MR. MS. MRS. MISS — LAST NAME — FIRST NAME — MIDDLE NAME

STREET ADDRESS

CITY — ZIP CODE

( ) HOME PHONE — ( ) WORKPHONE

BIRTHDATE MO/DAY/YEAR — AGE

PATIENT SOCIAL SECURITY #

Please Check
MALE ☐
FEMALE ☐

DRIVER'S LICENSE NUMBER

OCCUPATION — HOW LONG EMPLOYED?

EMPLOYER NAME

EMPLOYER ADDRESS — CITY — ZIP CODE

RELATIONSHIP TO PATIENT:
PARENT ☐ LEGAL GUARDIAN ☐ STEPPARENT ☐ OTHER _____

II. INSURANCE INFORMATION PARENT/RESPONSIBLE PARTY

Please Check
MALE ☐
FEMALE ☐

INSURED EMPLOYEE (PRIMARY)

MR. MS. MRS. MISS — LAST NAME — FIRST NAME — MIDDLE NAME

SOC. SEC.# (INSURED EMPLOYEE) — NAME OF EMPLOYER/COMPANY

DRIVER'S LIC.# (INSURED EMPLOYEE) — EMPLOYER ADDRESS CITY STATE

INSURANCE CO.(CARRIER) — ( ) EMPLOYER PHONE — DATE OF HIRE

PLAN/GROUP NUMBER — LOCAL NUMBER — DOB: / /

POLICY/I.D. # or MEDI-CAL I.D.#

III. DUAL INSURANCE INFORMATION

(Complete only if you or your spouse have additional insurance coverage)

Please Check
MALE ☐
FEMALE ☐

INSURED EMPLOYEE (SECONDARY)

MR. MS. MRS. MISS — LAST NAME — FIRST NAME — MIDDLE NAME

SOC. SEC.# (INSURED EMPLOYEE) — NAME OF EMPLOYER/COMPANY

DRIVER'S LIC.# (INSURED EMPLOYEE) — EMPLOYER ADDRESS CITY STATE

INSURANCE CO.(CARRIER) — ( ) EMPLOYER PHONE — DATE OF HIRE

PLAN/GROUP NUMBER — LOCAL NUMBER

POLICY/I.D. # or MEDI-CAL I.D.#

IV. GENERAL HEALTH INFORMATION

1. Are you under a doctor's care at this time? YES NO If yes, please specify _____
   Physician's name and phone number _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine ? _____
3. Are you taking any medication at this time? YES NO If yes, please specify _____
4. (Women) Are you pregnant at this time? YES NO If yes, please specify how many months _____
5. Do you now have or have you had any of the following ?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/ARC	☐	☐	DIABETES	☐	☐	PHEN PHEN	☐	☐	LATEX ALLERGIES	☐	☐
ALLERGIES	☐	☐	DIZZY SPELLS	☐	☐	HEART BYPASS	☐	☐	LOW BL PRESSURE	☐	☐
ANEMIA	☐	☐	EMPHYSEMA	☐	☐	HEART MURMUR	☐	☐	LUNG DISEASE	☐	☐
ANGINA	☐	☐	EPILEPSY	☐	☐	HEART PROBLEMS	☐	☐	RHEUMATIC FEVER	☐	☐
ARTHRITIS	☐	☐	FAINTING	☐	☐	HEPATITIS	☐	☐	SNORING	☐	☐
ASTHMA	☐	☐	FEVER BLISTERS	☐	☐	HIGH BL. PRESSURE	☐	☐	STROKE	☐	☐
CANCER	☐	☐	GLAUCOMA	☐	☐	JAUNDICE	☐	☐	THYROID PROBLEMS	☐	☐
PROSTHETIC HIP REPLACEMENT	☐	☐	HEART ATTACK	☐	☐	KIDNEY DISEASE	☐	☐	TUBERCULOSIS	☐	☐
						LIVER PROBLEMS	☐	☐	VENEREAL DISEASE	☐	☐
									BISPHOSPHONATES	☐	☐

6. Are there other conditions we should be aware of ? ☐ YES ☐ NO _____

V. DENTAL INFORMATION

7. Why are you here today ? Check-up☐ Cleaning☐ Toothache☐ Other _____
8. When did you last visit a dentist ? _____ 9. What treatment was performed ? _____
10. Was the treatment completed ?_____ 11. Did you have a cleaning ?_____ 12. When were dental X-rays last taken?_____
13. Haveyou ever had prolonged bleeding? YES NO
14. Have you had any problems with past dental treatment ? YES NO If yes, please specify _____
15. Doyour gums bleed easily ? YES NO 16. Doyou feel you have bad breath? YES NO 17. Are your teeth sensitive to hot or cold? YES NO

I HAVE REVIEWED HEALTH HISTORY WITH PATIENT.

_____
Signature of Doctor

I Have filled out this health questionnaire completely and have advised you of all medical problems of which I am aware. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist nor Arcadia Dental Group is responsible for my dental treatment.

_____
Signature of Patient or Responsible Party

_____ _____
Date Relationship

My dental treatment and possible allernatives have been discussed with me. I have been informed of all risks involved with my dental care and anesthesia, including possible blood loss and infection. I hereby consent to the administration of anesthesia and the dental treatments specified by the

_____
Signature of Patient

_____
Date

IN CASE OF EMERGENCY CONTACT:

_____ _____
Name Telephone #

- For Office Use Only -