Essential Smiles Dentistry
Where defining beauty comes naturally
Family & Cosmetic Dentistry

9430 WARNER AVENUE SUITE #H
FOUNTAIN VALLEY CA 92708
PHONE#: (714) 962-8884 FAX#: (714) 962-3777

We would like to welcome your whole family to our practice. Please take a few minutes to fill out this form as thoroughly as possible. Should you have any questions a member of our staff will be more than happy to assist you. We look forward to brightening your smile and maintaining your overall health.

PATIENT INFORMATION (*ADULT*)

Date:
Name:
Address:
City:
State: Zip:
Home Phone #:
Work #: Other #:
Email:
SSN:
Birth Date: Sex: (*circle one*) M or F
Status: (*circle one*) Single Married Divorced Widowed

PATIENT INFORMATION (*MINOR*)

Date:
Name:
Address:
City:
State: Zip:
Home Phone #:
Work #: Other #:
Email:
Attending School:
Birth Date: Sex: (*circle one*) M or F

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name:
Occupation:
Driver's License #:

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name:
Phone #:

DENTAL INSURANCE

PRIMARY	***SECONDARY***
Subscriber's Name:	Subscriber's Name:
Relationship to Patient:	Relationship to Patient:
Birth Date: SSN:	Birth Date: SSN:
Employer:	Employer:
Insurance Company:	Insurance Company:
Group #/Plan:	Group #/Plan:
Phone #:	Phone #:

DENTAL HISTORY *(Please circle yes or no to the following questions)*

What is the reason for your visit today?

What is the date of your last visit to the dentist?

Last dental cleaning?

What is the name of your previous dentist? What City?

Do you have any dental problems now?	YES	NO
(if so, can you please describe it?)_____		
_____		
Have you noticed any mouth odor or bad taste in your mouth?	YES	NO
Have you ever had orthodontics?	YES	NO
Have you ever had a bite plate or occlusal mouth guard?	YES	NO
Do your gums hurt or bleed?	YES	NO
Have you ever been told you have periodontal disease, gum disease, or bone loss?	YES	NO
Have you ever had gum surgery?	YES	NO
Have you ever had oral surgery? (Bone grafts, wisdom teeth removal, implants)	YES	NO
Have you experienced difficulty in opening or closing the mouth or pain in the joint on the side of the face in front of the ear?	YES	NO

HEALTH HISTORY *(Please circle yes or no to the following questions)*

Have you had a recent illness, surgery, or injury?	YES	NO
Have you been under the care of a physician during the last two years?	YES	NO

Physician's Name: _____ Phone#:_____Fax#:_____

Please circle YES or NO to any medication you may be allergic or sensitive to:

Penicillin	YES	NO	Aspirin	YES	NO
Tetracycline	YES	NO	Percodan	YES	NO
Erythromycin	YES	NO	Demerol	YES	NO
Sulfa Drugs	YES	NO	Codeine	YES	NO
Nitrous Oxide	YES	NO	Artificial flavoring	YES	NO
Latex	YES	NO	Base Metals	YES	NO
Other Antibiotics	YES	NO	Others	YES	NO

Have you ever taken Fosamax, Zometa, Boniva, Aredia, Actonel, Bonefos, Didronel, or Bisphosphonates for Osteoporosis or bone tumors? (*please circle*)	YES	NO

1. Have you been treated for heart disease?	YES	NO
2. Have you had a heart attack or stroke?	YES	NO
3. Do you have a pacemaker or artificial heart valve?	YES	NO
4. Have you been diagnosed with mitral valve prolapse?	YES	NO

5. Have you ever had rheumatic fever? YES NO
6. Are you aware of any heart murmurs? YES NO
7. Do you have **HIGH or LOW** blood pressure? *(please circle)* YES NO
8. Have you had major heart bypass surgery or stents placed? YES NO
9. Do you have congestive heart disease? YES NO
10. Have you had a recent blood transfusion? YES NO
11. Do you have diabetes? What medications are you taking for diabetes? YES NO
12. Do you have inflammatory diseases such as arthritis? YES NO
13. Do you have any artificial joints/prosthesis? YES NO
14. Do you have any blood disorders such as Anemia or Leukemia? YES NO
15. Have you ever bled excessively after being cut or injured? YES NO
16. Do you have any stomach problems? YES NO
17. Do you have any kidney problems? YES NO
18. Do you have any liver problems? YES NO
19. Do you have fainting or dizzy spells? YES NO
20. Do you have asthma? YES NO
21. Do you have epilepsy or seizure disorders? YES NO
22. Do you have a **VENEREAL DISEASE, SYPHILIS, GONORRHEA, WARTS, HERPES**? *(please circle)* YES NO
23. Have you tested HIV positive? YES NO
24. Do you have AIDS? YES NO
25. Do you have or ever had Tuberculosis? YES NO
26. Do you have Hepatitis A Hepatitis B Hepatitis C Hepatitis D? *(please circle)* YES NO
27. Have you had psychiatric treatment? If so, for what diagnosed problem?_____

_____

_____

28. Do you smoke, chew, use snuff or any forms of tobacco? YES NO
29. For women: Are you pregnant? If so, how far along are you?
    Are you nursing? YES NO
    Are you taking any form of contraception or antibiotics? YES NO
30. Have you taken any prescription drugs such as Fen-Phen or Redux? YES NO
31. Do you take herbal supplements? If so, what?_____

_____

32. Are you currently taking prescription drugs? If so, what?_____

_____

_____

33. Do you have any disease, condition or problem not listed? If so, what?_____

_____

_____

34. Is there anything else you would like to bring to our attention regarding your health? If so, what?_____

_____

_____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information. I will notify the doctor of any changes in my health or any new medications used.

Patient/Parent/Guardian signature:_____ **Date:**_____
Dentist's signature: _____ **Date:**_____