CYPRESS DENTAL CARE

4971 Orange Ave. Cypress, CA 90630
Tel: (714) 826 – 4640 / Fax: (714) 826 – 4672
Email: cypressdental817@gmail.com
Website: www.cypressdental .us

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ Middle Initial: _____

Preferred Name: _____ Patient Is: Policy Holder ○ Yes ○ No

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ Work: _____

Preferred to call: (please circle) Home Cell Work Best time to call: _____ AM / PM

Birth Date: _____ Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Other _____

Social Security: _____ Email: _____

Occupation: _____ Employer: _____

How did you hear about our office? Yelp Facebook Google Other: _____

Responsible Party or Policy Holder (don't fill this out if you are patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Birth Date: _____ Social Security/Subscriber ID: _____ Relationship to this patient: _____

Dental History Questionnaires

Please answer each question by circling Yes or No

Would you like to straighten your teeth? _____ Yes / No

Do you have a specific dental problem or complaint? Describe: _____ Yes / No

Do you have dental examinations on a routine basis? If Yes, When was your last visit? _____ Yes / No

Do you want to have your teeth whitening? _____ Yes / No

Do you brush and floss on a routine basis? How often? _____ Yes / No

Do your gums ever bleed? Describe: _____ Yes / No

Do you snore and want to get treated? _____ Yes / No

Do you want to keep your remaining teeth? _____ Yes / No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes / No

Have your past experiences in a dental office been positive? _____ Yes / No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent, or Guardian: _____ Relationship: _____ Date: _____

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HEALTH HISTORY

PATIENT NAME _____

Please answer each question by checking the appropriate box or circling Yes or No

Are you under a physician's care now (Other than routine check up)? If Yes, please explain:_____ Yes / No

Have you ever been hospitalized or had a major operation? If Yes, please explain: _____ Yes / No

Have you ever had a serious head or neck injury? If Yes, please explain: _____ Yes / No

Are you taking any medications, pills, or drugs? If Yes, please explain: _____ Yes / No

Do you have Prosthetic Implants? If yes, please explain: _____ Yes / No

Do you use smoke or use tobacco products? If yes, how much a day: _____ Yes / No

Do you use any recreational drugs (e.g., Marijuana, Cocaine) or controlled substances? _____ Yes / No

Do you wear a cardiac pacemaker, or have you had heart surgery? If Yes, please explain: _____ Yes / No

Are you allergic to any of the following: Penicillin, Sulfa, Codeine? If Yes, please list: _____ Yes / No

Female: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No If Yes, how many months? _____ Taking birth control pills? ○ Yes ○ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Renal Dialysis	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Herpes	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Angina	☐	☐	Epilepsy/Seizures	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Asthma	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Stomach Disease	☐	☐
Blood Disease	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Bruise Easily	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Heart Attack/Failure	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Chest Pains	☐	☐	Heart Murmur	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Cold Sores	☐	☐	Heart Pace Maker	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Congenital Heart Defect	☐	☐	Heart Trouble/Disease	☐	☐	Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐	DR. INITIAL: _____		

Patient Responsible for Fees & Assignment of Insurance Benefits: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on the date which services are provided. I hereby authorize that the payments from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees.

Responsible Party Signature: _____ Relationship _____ Date _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient or Guardian _____ Relationship _____ Date _____