Lisa Y. Cannatella, D.D.S
Steven R. Czekala, D.D.S
Priyanka Moonka, D.D.S

9301 Fircrest Lane, Suite 7
San Ramon, California 94583
Phone (925) 828-5335 Fax (925) 829-6170
www.smilesanramon.com

Patient Information & Health History Form (PLEASE PRINT LEGIBLY)

Patient's Last Name_____First_____Middle_____**DATE**_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Email Address_____Social Security #_____Age_____Date of Birth _____

Sex: M ❑ F ❑ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partnered ❑ Minor

If a Full Time Student, Name of College & City _____

Has any member of your family been seen in our office? Yes ❑ No ❑ If Yes, Name_____Relationship _____

Family Name for Billing Purposes (Main Account Holder's Last Name)_____

Billing Address, If Different From Above_____

Do you have Dental Insurance? Yes ❑ No ❑ If Yes, please complete Dental Insurance Information Form

Patient's (Or Parent's) Employer_____Work Phone, If Different from Above (_____)_____

Position_____

Employer's Address_____City_____State_____ Zip_____

Spouse's Name_____Spouse's Social Security #_____

Spouse's Employer_____Spouse's Work Phone (_____)_____

Emergency Contact_____ Phone (_____)_____

If referred to our office, by whom? (Name of Person, Family Member, Dentist, Yellow Pages, Etc.)_____

DENTAL INFORMATION

Reason for today's visit_____Date of last dental exam_____

Former Dentist_____Phone (_____)_____Date of last dental X-rays_____

How often do you brush?_____How often do you floss?_____

Describe your current dental problem, if any: _____

Any serious problem/difficulties in your dental history?_____

Check all that apply:

- ❑ Bleeding gums
- ❑ Periodontal (gum) treatment
- ❑ Bad breath
- ❑ Sensitivity to hot/cold/sweet/pressure
- ❑ Past orthodontics (braces) treatment
- ❑ Currently wear removable appliance
- ❑ Sores or growths in your mouth
- ❑ Loose or broken teeth
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Earaches or neck pains

MEDICAL INFORMATION

Physician's Name_____Phone (_____)_____Date of last physical exam_____

Are you in good health?_____ Any health changes in the past year?_____

Are you currently being treated/under a doctor's care?_____If so, for what condition?_____

Any serious illness/operation/hospitalization in the past 5 years?_____If so, for what condition?_____

Do you premedicate with antibiotics before dental treatments? _____If so, which antibiotic?_____

Are you allergic to, or ever had a reaction to any of the following? Yes ❑ No ❑ If Yes, check all that apply:

- ❑ Penicilllin
- ❑ Local anesthetics
- ❑ Latex
- ❑ Aspirin
- ❑ Barbituates, sedatives, sleeping aids
- ❑ Sulfa drugs
- ❑ Codeine or other narcotics
- ❑ Iodine
- ❑ Metals (specify) _____
- ❑ Antibiotics (specify)_____
- ❑ Other allergies:_____

Women Only:

Are you, or could you be pregnant?_____Nursing?_____Taking birth control pills or hormone replacement?_____

(PLEASE TURN OVER TO COMPLETE FORM)

MEDICAL INFORMATION (Continued)

Are you taking, or recently have taken any medications, including prescription drugs and recreational drugs, or injections? _____

If so, list: _____

_____

_____

_____

Have you ever taken Fosamax?_____ Have you ever taken any diet drugs such as Phen-fen? _____

Do you use tobacco (smoking, snuff, chew)?_____ Are you taking blood thinners?_____

Check all that apply if you've had or have any of the following:

- ❑ Abnormal Bleeding
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma, Emphysema, Lung Disorders
- ❑ Back Problems
- ❑ Blood Disease, Blood Transfusion
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chest Pain Upon Exertion
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Diabetes
- ❑ Dry Mouth
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Excessive Urination
- ❑ Fainting, Seizures
- ❑ Gastrointestestinal Disease
- ❑ G.E. Reflux/Persistent Heartburn
- ❑ Glaucoma
- ❑ Headaches, Migraines
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Infections, Recurrent
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Radiation Treatment, Chemotheraphy
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Systemic Lupus Erythematosus
- ❑ Stroke
- ❑ Swollen Feet or Ankles
- ❑ Swollen Glands in Neck
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease

Cardio Vascular Disease. Which of the following apply?

- ❑ Angina
- ❑ Arteriosclerosis
- ❑ Artificial Heart Valves
- ❑ Congenital Heart Defects
- ❑ Congenital Heart Failure
- ❑ Coronary Artery Disease
- ❑ Damaged Heart Valves
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Rheumatic Heart Disease

Please explain any other health concerns (disease, condition, or problem) not listed above:_____

_____

_____

_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform this office if I, or my minor child, have a change in health. Even if no information has changed, this form must be updated every 5 years.

This dental office may use this health care information, and disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and for determining insurance benefits or the benefits payable for related services.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

PATIENT, PARENT OR LEGAL GUARDIAN

Copayments are due in full at the time of treatment unless prior arrangements have been approved