

Drs. Bobby and Anoop Bawa, as well as the entire dental team welcome you to First Dental Care. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. This information is confidential. We look forward in helping you maintain good dental health as your dental health is our first priority.

Patient Information

Patient's Name: _____
 Home Phone #: () _____ Work Phone: () _____ Email _____
 Social Security #: _____-_____-_____ Birthdate: ___ / ___ / ___ Age: _____ Sex _____
 Marital Status: Single Married Divorced/Separated Widowed
 Address: _____ City: _____ Zip: _____
 Patients Employer: _____ Occupation: _____
 Spouse's Name: _____, _____ Spouse's Employer: _____
 Person to contact in case of an emergency: _____ Phone #: _____
 Is the patient a student? Full Time Part Time School: _____

Responsible Party's Information

Person Responsible for Account: _____ Relation to Patient _____
 Home Phone: (_____) _____ Work Phone: (_____) _____
 Mailing Address: _____ City: _____ Zip: _____
 Social Security #-: _____-_____-_____ Drivers License #: _____
 Employer: _____ Occupation: _____
 Employer's Address: _____ City: _____ Zip: _____
 Have you or any member of your family been a patient at this office before? YES NO
 If YES, Name: _____

Primary Dental Insurance: YES NO

Insured's Name: _____
 SS#: _____-_____-_____ DOB: ___/___/___
 Employer: _____
 Insurance Company/Plan: _____
 Union/ Group Name: _____
 Group or Policy #: _____ Local#: _____
 Date Employed: _____

Secondary Dental Insurance: YES NO

Insured's Name: _____
 SS#: _____-_____-_____ DOB: ___/___/___
 Employer: _____
 Insurance Company/Plan: _____
 Union/ Group Name: _____
 Group or Policy #: _____ Local#: _____
 Date Employed: _____

Who may we thank for recommending our office to you _____
 Otherwise, how did you choose our practice? Insurance plan Yellow pages Mailer/AD
 Other source: _____

Patient's Dental History

Are you in pain now? _____

What is the primary reason for your Dental visit? _____

Are you aware of any Dental problems? If so, please explain: _____

Name of your previous Dentist: _____

Date of last Dental Exam/Cleaning: _____ Date of last X-rays: _____

Did your last Dentist recommend any dental treatment for you? If so please describe: _____

Have you had any complications with dental procedures in the past? _____

Please Indicate Past Dental Treatments:

- Root Canal Therapy? YES NO
- Extractions/Oral surgery? YES NO
- Orthodontics (braces)? YES NO
- Gum Surgery/ Deep Cleaning? YES NO
- Dental Implants? YES NO
- Treatment for TMJ? YES NO

Are you currently experiencing any of the following?

- TMJ/ Jaw Pain? YES NO
- Bleeding/Swollen gums? YES NO
- Grinding/Clenching teeth? YES NO
- Bad Breath? YES NO
- Sensitivity to Sweets/Hot/Cold? YES NO
- Pain when Chewing? YES NO

Are you interested in Cosmetically Improving your Smile? If so please explain: _____

Are you interested in Dental Whitening? YES NO

Patient's Medical History

Name of your Physician: _____ Phone #: _____

Date of your last Medical Exam: _____ Findings: _____

Are you currently undergoing any Medical Treatment? _____

Have you been Hospitalized within the past 5 years? If so, for what reason? _____

List all Medications that you currently take:

Medication	Reason
_____	_____
_____	_____

If you have Allergies to any Medications, please list them: _____

Have you have had Surgeries in the past? Please list them with dates: _____

Please check each box, yes or no, if the patient has or has ever had any illness or conditions listed below.

Please don't leave it blank.

- | | | | |
|---|--|--|--|
| Abnormal Bruising/Bleeding | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart attack | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| AIDS/HIV | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergy to Latex or Sensitivity | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies to Local Anesthesia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A/B/C | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Allergies to Penicillin/Antibiotics | <input type="checkbox"/> YES <input type="checkbox"/> NO | High or low blood pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hyperglycemia/Hypoglycemia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis/Rheumatism/Painful swollen joints | <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaundice | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma/Emphysema/Respiratory problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Kidney disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial joints | <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial heart valve | <input type="checkbox"/> YES <input type="checkbox"/> NO | Malignant hyperthermia | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood Disorders/Transfusion | <input type="checkbox"/> YES <input type="checkbox"/> NO | Mitral valve prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer/Radiation/Chemotherapy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Psychiatric treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cardiac pacemaker | <input type="checkbox"/> YES <input type="checkbox"/> NO | Persistent cough, coughing up blood | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain/Shortness of breath | <input type="checkbox"/> YES <input type="checkbox"/> NO | Phen-Fen, Pondimin or Redux consumption | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Circulation problems | <input type="checkbox"/> YES <input type="checkbox"/> NO | Recent weight loss/gain | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital heart defects | <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatic/Scarlet fever | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Contact lenses | <input type="checkbox"/> YES <input type="checkbox"/> NO | Sickle cell disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cold sores/Fever blisters | <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone/Steroid therapy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stomach ulcers or digestive problems | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Epilepsy or seizures | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Fainting or dizziness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Frequent vomiting, nausea | <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal disease (STDs) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Glaucoma or other eye disease | <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you currently pregnant? If yes, how many months? _____ | |
| Head or neck injury | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you use tobacco? If yes, what type and frequency? _____ | |
| Hearing difficulties/Earache | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you drink alcohol? If yes, how much? _____ | |

Are there any conditions not listed above that you presently have or ever had?

Is there anything else you wish to discuss with your dentist?

Has your child recently had:

- Chicken pox YES NO
- Strep throat YES NO
- Measles YES NO
- Tonsilitis YES NO
- Mumps YES NO
- Any traumatic experience YES NO

I, the undersigned, certify that all personal and medical - dental history is accurate and complete to the best of my knowledge. I have not knowingly omitted any information. I understand that it is my responsibility to inform this dental office of any changes in my health. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment as well as all prophylactic procedures (cleaning). I understand it may be necessary to have information provided from or to my medical doctor or another health care provider, hence I consent to the release of this information.

X _____ Date _____
(signature) Patient Parent Guardian

Doctors Signature: _____ Date _____
Comments: _____

Recall Review

There have been no changes in my health history.

Patient's Signature: _____ Date _____

Doctors Signature: _____ Date _____

Comments: _____

Recall Review

There have been no changes in my health history.

Patient's Signature: _____ Date _____

Doctors Signature: _____ Date _____

Comments: _____

Recall Review

There have been no changes in my health history.

Patient's Signature: _____ Date _____

Doctors Signature: _____ Date _____

Comments: _____
