Welcome to Village Oaks Dentistry, please take your time to fill out this form.

First: _____ Last: _____ Nickname: _____
Gender: M / F DOB: ___/___/_____

General Informations (Complete all that applies)

Home: (_____)_____-_____
Work: (_____)_____-_____
Cell: (_____)_____-_____
Smartphone? Y/N
May we send text messages to your cell phone? Y/N
Email: _____
Prefer Method: Cell / Work / Home / Email / Text
Emergency Contact Name: _____
Emergency Contact Phone: (____) ____-_____

Mailing Address: _____
_____
City: _____ State / Zip: ___ _____

(If different than Home Address)
Billing Address: _____
_____
City: _____ State / Zip: ___ _____

Other Information

My SSN: _____-____-_____
Check ☒ if it is applicable to you
☐ Full-time Student ☐ Part-time Student

Family Physician: _____ Tel: (____) ____-_____
Date of Last Physical Exam: ___/___/_____

How did you find us (☒ if applicable)?

☐ Google ☐ Yelp ☐ Flyers ☐ Friend (name): _____
☐ Facebook ☐ Yellow pages ☐ Just walked by ☐ Other: _____

General Health and History (☒ Y or N for each question)

Y N

☐ ☐ Are you in pain now? If YES, explain: _____
☐ ☐ Do you need pre-medication for dental treatment?
If Yes, explain: _____
☐ ☐ Have you taken any of the following medicine?
Bisphosphonates – FOSAMAX, ACTONEL, BONIVA, ZOMETA, AREDIA
☐ ☐ Have you had previous dental treatments?
Date of Last Dental Visit: _____ Date of Last X-rays: _____
Date of Last Cleaning: _____ Date of Last Deep Cleaning*: _____
Age of Denture if any*: _____ Braces*: Now / Past / Never
Wearing Retainer*: Y / N Wisdom teeth extracted*: Y / Some / N / Don't know
Any problems with prior dental treatments? *: _____

Women Only (☒ Y or N for each item)

Y N ☐ ☐ Pregnant, est Delivery date *: __/__/____
Y N ☐ ☐ Taking birth control pills
Y N ☐ ☐ Nursing*

Current or Recent Usage of Drugs (☒ Y or N for each item)

Y N ☐ ☐ Tobacco
Y N ☐ ☐ Alcohol
Y N ☐ ☐ Diet Pills
Y N ☐ ☐ Recreational drugs
Y N ☐ ☐ Herbal / Supplements
Y N ☐ ☐ Provide a list of your prescriptions*: _____
_____
_____ (ask for a new page if needed)

Patient Name: _____ DOB: ___/___/_____

Allergies (☒ if applicable)

Y	N		Y	N		Y	N	
☐	☐	Latex	☐	☐	Hydrocodone	☐	☐	Codeine
☐	☐	Nitrous oxide	☐	☐	Antibiotics: _____	☐	☐	Others* (e.g. food and metal):
☐	☐	Aspirin			_____			_____
☐	☐	Local anesthetics			_____			_____

Specific Health Issues (☒ if applicable)

Y	N		Y	N		Y	N	
☐	☐	Hospitalization / Surgeries / Transplants	☐	☐	Joint Replacement	☐	☐	Liver disease
☐	☐	Please Explain*: _____	☐	☐	Arthritis	☐	☐	Eating disorders
		_____	☐	☐	Osteoporosis	☐	☐	Kidney disease
		_____	☐	☐	Skin disease	☐	☐	Stomach problems
☐	☐	Diabetes	☐	☐	Anemia	☐	☐	Eye disease: _____
☐	☐	High blood pressure				☐	☐	Thyroid Issues: _____
☐	☐	Heart disease / defects: _____	☐	☐	Herpes / Zoster	☐	☐	Asthma
☐	☐	Heart attack: (date)_____	☐	☐	Hepatitis	☐	☐	Tuberculosis: _____
☐	☐	Heart murmurs	☐	☐	AIDS/HIV	☐	☐	Emphysema: _____
☐	☐	Hardening of arteries	☐	☐	Other STDs			
☐	☐	Rheumatic fever / Rheumatism	☐	☐	Canker or cold sores	☐	☐	Others: _____
☐	☐	Seizures* : (date) _____						_____
☐	☐	Stroke* : (date) _____	☐	☐	Cancer: _____			_____
☐	☐	Psychiatric / Mental care	☐	☐	Chemotherapy			_____
			☐	☐	Radiation Therapy			

Symptoms (☒ if applicable)

Y	N		Y	N		Y	N	
☐	☐	Non-dental Pain	☐	☐	Coughing up blood	☐	☐	Dry mouth
☐	☐	Fainting, Dizziness	☐	☐	Bruise easily	☐	☐	Difficulty swallowing
☐	☐	Significant weight loss	☐	☐	Blood in urine / in stools	☐	☐	Swollen ankles
☐	☐	Night sweats	☐	☐	Diarrhea or constipation	☐	☐	Joint pain or stiffness
☐	☐	Persistent cough	☐	☐	Issue with urination	☐	☐	Ringing in ears
☐	☐	Shortness of breath	☐	☐	Frequent vomiting	☐	☐	Others: _____
☐	☐	Sinus problems	☐	☐	Jaundice			_____

Please read and check ALL boxes ☒ on the following:

- ☐ I authorize the dentist to contact my physician if the dentist determines that there may be a potentially medically compromised situation.
- ☐ I certify that I have read and understood this form (regarding my medical history) and answered every question to the best of my knowledge. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.
- ☐ I was given the HIPAA agreement (separate) and had a chance to review it and ask questions. I understand that I can request copies of the HIPAA agreement at any time.
- ☐ I was given the Dental Material Fact Sheet. I understand that I can obtain this from Dental Board of California's official website as well. http://www.dbc.ca.gov/

Signature of Patient/Guardian: _____ Date: _____

Patient Name: _____ DOB: ___/___/_____

DENTAL INSURANCE

Please present your insurance card to our patient service representative.

Primary Insurance	
Subscriber Name	
Subscriber SSN	
Subscriber Birthdate	
Relationship to Patient	Self / Spouse / Child / Other
Employer Name	
Employer Phone	
Insurance Company	
Insurance Address	
Insurance Phone#	
Insurance Group#	
Insurance Local#	

Secondary Insurance	
Subscriber Name	
Subscriber SSN	
Subscriber Birthdate	
Relationship to Patient	Self / Spouse / Child / Other
Employer Name	
Employer Phone	
Insurance Company	
Insurance Address	
Insurance Phone#	
Insurance Group#	
Insurance Local#	

Please provide your dental insurance card to our Office Manager. Thank you.

Signature of Patient/Guardian: _____ Date: _____