Jon M. Koeltl, D.D.S.
Richard P. Usinger D.D.S.

The Diablo Dental Group
156 Diablo Road, Suite 202
Danville, CA 94526

Gregory A. Hong, D.D.S.
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Patient Information

First Name:	Middle Initial:	Last Name:	DOB: / /	Nickname:
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ M ☐ F	Social Security # - -		Drivers License & State
Address:	City:	State:	Zip:	
Main Phone:	2nd/Cell Phone/Work	Email:		
Full Time Student? Yes_____ No_____	Name of School_____			

Person Responsible for Account

First Name:	Middle Initial:	Last Name:	DOB:
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone	Email:	
Employer:	Employer Address: Work Phone:	Relationship to Patient:	

Primary Insurance

Name of insured:	Relationship to Patient:	DOB: SSN or ID#: Phone: ( ) -
Employer:	Insurance Co. & Address:	
Group #:		

Secondary Insurance

Name of insured:	Relationship to Patient:	DOB: SSN or ID#: Phone: ( ) -
Employer:	Insurance Co. & Address:	
Group #:		

How did you hear about our office?
(check only one)

☐ Ref. by friend/coworker ☐ 1-800-Dentist ☐ Insurance Plan ☐ Signage/Drive by ☐ Community ☐ Online Search Engine Which One?_____

If you were referred whom may we thank for referring you? _____

In the event of an emergency please contact:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

By signing this form, I agree to the following Terms/Condition/Release: Unless otherwise arranged, PAYMENT IS DUE AT THE TIME OF SERVICE. A FEE may be charged to patients who cancel appointments without 48 hour notice. I authorize the release of information to process any claims. I further assign payment directly to Dr. Jon M. Koeltl, D.D.S. If Dr. Jon M. Koeltl, D.D.S. extends delayed payment privileges to me, I authorize verification of my credit history and capacity. I acknowledge that I AM RESPONSIBLE FOR ALL MONIES DUE TO THE DIABLO DENTAL GROUP NOT PAID BY MY INSURANCE for services rendered as described in my claim(s). A service charge of 1 1/2% per month will be charged on all accounts after 60 days. There is a $25 returned check fee.

SIGNATURE OF PATIENT (OR GUARDIAN)

DATE

Medical History

Why have you come to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ / Phone # _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes, please tell us why: _____

Speech problems/therapy?	Yes	No	Brush teeth daily?	Yes	No
Grind or clench teeth	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Mouth breathing?	Yes	No
Injury to face, jaw, teeth or mouth?	Yes	No	Snore during sleep?	Yes	No
Discomfort from teeth or gums?	Yes	No	Frequent headaches?	Yes	No
Pain, tenderness or noise from either jaw?	Yes	No	Any missing or extra permanent teeth??	Yes	No
Neck/shoulder pain?	Yes	No	Frequently chew gum?	Yes	No
Frequent sore throats?	Yes	No			
Do parents want child to have Fluoride?	Yes	No			

If any of the above dental questions were answered "Yes", please explain: _____

I consider my health to be (please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? Please circle Y for yes or N for no

Physician Name	Date of last physical	Patient Health
Address:	City / State / Zip	

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints ☐Hip ☐Knee ☐ Other
16. Y N I smoke or use tobacco. If yes, how much per day? ____ How many years? ____
17. Y N I usually take an antibiotic prior to dental treatment
18. Y N Have you ever taken Fen-Phen, Redux or Fosomax?
19. Y N I have had major surgery Year _____ Type of operation: _____ Year _____ Type of operation: _____
20. Y N Do you have any other medical problem or medical history NOT listed on this form?
21. Y N Liver Disease
22. Y N Jaundice
23. Y N Hepatitis Type ____
24. Y N Diabetes
25. Y N Excessive Urination and/or Thirst
26. Y N Infectious Mononucleosis
27. Y N Herpes
28. Y N Arthritis
29. Y N Sexually transmitted/Venereal Disease
30. Y N Kidney Disease
31. Y N Tumor or Malignancy
32. Y N Cancer/Chemotherapy
33. Y N Radiation Treatment
34. Y N History of Drug Addiction
35. Y N AIDS/HIV
36. Y N Immune Suppressed Disorder
37. Y N Hearing Loss
38. Y N Fainting Spells
39. Y N Glaucoma
40. Y N History of Emotional or Nervous Disorders
41. Y N Thyroid
42. Y N Pacemaker
43. Y N High Blood Pressure

WOMEN

44. Y N Are you taking birth control medication?
45. Y N Are you or could you be pregnant or nursing?

Are you allergic to any of the following?
Please circle Y for yes or N for no

45. Y N Aspirin
46. Y N Ibuprofen
47. Y N Sulfa Drugs/Sulfites/Sulfides
48. Y N Penicillin
49. Y N Codeine
50. Y N Latex, Metals, Plastics
51. Y N Local Anesthetics (Novocaine)
52. Y N Other Medications - Which ones? _____

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

Physician's Name _____ Phone _____

Address _____ Fax _____

To the best of my knowledge, all of the preceding answers are true and correct. I realize that it is important to inform my dentist or the hygienist of any changes in my health.

For your benefit, a thorough examination (including X-rays) is necessary before an accurate diagnosis can be reached and proper treatment rendered. I authorize Jon M. Koeltl, D.D.S., his associates, and/or his staff to perform whatever services and use whatever anesthetics their professional judgment deems necessary for proper treatment in my dental care.

Date: _____ Signature of Patient or Guardian: _____

Date: _____ Reviewed by Doctor: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS	PATIENT SIGNATURE	BP	REVIEWED BY
_____	_____ None ☐	_____	_____	_____
_____	_____ None ☐	_____	_____	_____