Please be assured that all of the information you provide will remain strictly confidential

Patients full name:____ Date:____________________
Last First MI Title

Preferred name:_______________________________ Sex: ◯ Male ◯ Female

Address:____
Street City State Zip Code

SSN#:________________________ DOB:____________________________________

Home phone#:__________________ Work#:______________________ Cell#:____________________

Email address:____

Occupation:_________________________ Employer:____

Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯ Domestic Partner

In case of emergency, notify:_______________________ Relation:_______________ Phone#:_____________

Referred by:_______________________________ Relation:____________________________________

Insurance – Primary

For office use only *- Insurance card has been scanned:* ◯

Subscriber name:__________________ Relationship to patient:_______________ Subscriber DOB:_____________

Subscriber SSN/ID#:__________________ Subscriber employer:__________________ Group#:_______________

Insurance company name:__________________________ Insurance company phone#:_________________________

Insurance company address:____
Street City State Zip Code:

Insurance – Secondary

Subscriber name:__________________ Relationship to patient:_______________ Subscriber DOB:_____________

Subscriber SSN/ID#:__________________ Subscriber employer:__________________ Group#:_______________

Insurance company name:__________________________ Insurance company phone#:_________________________

Insurance company address:____
Street City State Zip Code:

Assignment and Release

Please read, initial and sign the following (if patient is a minor, parent or guardian must initial and sign)

_________ I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Cupertino Dental Group all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize payment directly to the dentist named on the attached claim of the group insurance benefits otherwise payable to me. I authorize the use of this signature on all insurance submissions.
Initial

_________ I give my consent to use local anesthetic, general anesthetic, or relaxants for completing necessary dental treatment.
Initial

_________ I have received from the office of Cupertino Dental Group a copy of the **DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES.**
Initial

_________ I authorize my dentist at Cupertino Dental Group to contact my physician in the form of a medical release, if necessary.
Initial

Patient (parent/guardian) signature:____ Date:_______________

Medical History

Physician's name:____________________ Physician's phone:____________________

Date of last visit:____________________ Your current physical health is: ◯ **Good** ◯ **Fair** ◯ **Poor**

Are you currently under the care of a physician? ◯ **Yes** ◯ **No** If yes, please explain:____________________

Have you been hospitalized with a serious illness in the last three years? ◯ **Yes** ◯ **No** If yes, please explain:____________________

____

Do you use tobacco (smoke, chew, hookah, vape, etc.)? ◯ **Yes** ◯ **No** If yes, how much and how long?____________________

Have you had a surgical implant (i.e. joint replacement) or artificial valve? ◯ **Yes** ◯ **No** If yes, please describe and include year of surgery:____________________

____

Please list any medications that you are on:____________________

____

Are you currently or have you ever taken bisphosphonates (including *denosumab, zolendronate, pamidronate, fosamox, boniva, actonel, prolia*)? ◯ **Yes** ◯ **No**

If yes, how much and for how long?____________________

Do you take anticoagulants/blood thinners (*coumadin, eliquis, Plavix, daily aspirin,* etc.) ◯ **Yes** ◯ **No** yes, please list:____________________

____

Have you ever had excessive bleeding requiring special treatment? ◯ **Yes** ◯ **No** If yes, please explain:____________________

____

Have you ever had general anesthesia? ◯ **Yes** ◯ **No** If yes, please explain:____________________

Have you ever had radiation treatment for cancer therapy? ◯ **Yes** ◯ **No** If yes, please explain:____________________

Have you ever responded unfavorably to medical or dental care? ◯ **Yes** ◯ **No** If yes, please explain:____________________

____

Have you ever had an unfavorable reaction to nitrous oxide (laughing gas)? ◯ **Yes** ◯ **No** If yes, please explain:____________________

Must you sleep with your head on more than one pillow? ◯ **Yes** ◯ **No** If yes, please explain:____________________

Height:____________________ Weight: ____________________

Have you ever had or experienced any of the following?

Yes	**No**	
◯	◯	Recent illness-past year
◯	◯	Heart or chest pain
◯	◯	Heart attack
◯	◯	Heart trouble
◯	◯	Heart murmur
◯	◯	Rheumatic fever
◯	◯	Mitral valve prolapse
◯	◯	Prosthetic heart valve
◯	◯	Pacemaker
◯	◯	Shortness of breath
◯	◯	High blood pressure
◯	◯	Low blood pressure
◯	◯	Organ transplant
◯	◯	Stroke
◯	◯	Parkinson's disease
◯	◯	Fainting
◯	◯	Lung disease
◯	◯	Asthma, emphysema, TB (circle)
◯	◯	Bronchitis
◯	◯	Cancer
◯	◯	Radiation treatment

Yes	**No**	
◯	◯	Facial radiation therapy
◯	◯	Chemotherapy
◯	◯	Diabetes I or II (circle)
◯	◯	Kidney disease
◯	◯	Liver disease
◯	◯	Hepatitis A B C D (circle)
◯	◯	Convulsions / epilepsy (circle)
◯	◯	Thyroid condition
◯	◯	Bleeding tendency
◯	◯	Anemia
◯	◯	Artificial joint
◯	◯	Venereal disease
◯	◯	Herpes
◯	◯	HIV / AIDS (circle)
◯	◯	Family history of diabetes, heart disease (circle)
◯	◯	Eye disease
◯	◯	Contact lenses
◯	◯	Skin disease
◯	◯	Psychiatric care
◯	◯	Blood transfusions
◯	◯	Cortisone, ACTH, Prednisone (circle)

Yes	**No**	
◯	◯	Recreational Drugs
◯	◯	Substance Abuse
◯	◯	Medical Marijuana

Any allergies/unusual reactions to:

Yes	**No**	
◯	◯	Penicillin
◯	◯	Sulfa
◯	◯	Codeine
◯	◯	Aspirin
◯	◯	Latex
◯	◯	Iodine
◯	◯	Dental anesthetics
◯	◯	Metals
◯	◯	Erythromycin
◯	◯	Other:____________________

If female, please answer:

Yes	**No**	
◯	◯	Are you taking birth control pills?
◯	◯	Are you pregnant?
		If so, # weeks:____________________
◯	◯	Are you nursing?

Do you have or have you had any other disease or medical condition **NOT** listed on this form? ◯ **Yes** ◯ **No**

If so, please explain:____________________

To the best of my knowledge, I have answered all subsequent questions completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient (parent/guardian) signature:____________________ Date:____________________

Recall Review

Changes:____________________	Pt.'s initials:____________________	Date:____________________	Dr./Hyg.: __________
Changes:____________________	Pt.'s initials:____________________	Date:____________________	Dr./Hyg.: __________
Changes:____________________	Pt.'s initials:____________________	Date:____________________	Dr./Hyg.: __________
Changes:____________________	Pt.'s initials:____________________	Date:____________________	Dr./Hyg.: __________