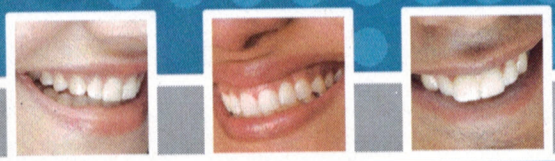
City Dental Group
1186 Brittan Ave
San Carlos CA 94070

(650)595-2489



MEDICAL HISTORY AND PATIENT INFORMATION

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____
_____ (City) _____ (State) _____ (Zip Code)

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

What is your reason for today's visit?

☐ Pain ☐ Check up ☐ New Patient ☐ Consultation

If you are in PAIN, what are your sysmptoms?

_____

Previous Dentist or Dental Office

_____

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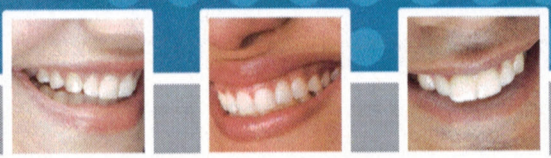

Your last dental visit?

What problems have you had with your previous Dental Treatment?

Are you nervous about seeing a dentist?

◯ Yes ◯ No

PLEASE CHECK BOX IF ANY OF THE QUESTIONS APPLY TO YOU?

- ☐ I grind my teeth during the day or night
- ☐ My gums bleed while brushing or flossing
- ☐ Clicking or Popping Jaw
- ☐ Loose or Broken tooth
- ☐ Broken filling(s)
- ☐ I want my teeth whiter
- ☐ I like my smile
- ☐ I have had orthodontic treatment
- ☐ Sensitivity to cold or hot (please circle one)
- ☐ Dry Mouth
- ☐ Sensitivity to sweets
- ☐ Bad breath

HOW OFTEN DO YOU BRUSH YOUR TEETH?

☐ Once a day ☐ Twice a day ☐ Sometimes ☐ Never

HOW OFTEN DO YOU FLOSS?

☐ Once a day ☐ Twice a day ☐ Sometimes ☐ Never

I CONSIDER MY HEALTH TO BE:

☐ Good ☐ Fair ☐ Poor

WOMEN ONLY

- ☐ Are you pregnant?
- ☐ Are you Nursing?
- ☐ Are you taking birth Control pills?

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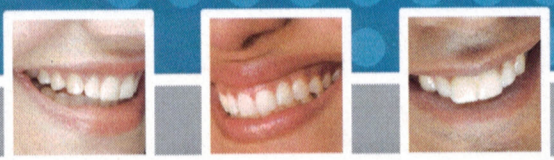

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Erythromycin
- ☐ Nitrous Oxide
- ☐ Darvon
- ☐ Valium
- ☐ Tetracycline
- ☐ Metal
- ☐ Codeine
- ☐ Demerol
- ☐ Vicodin
- ☐ Sulfa
- ☐ Latex
- ☐ Penicillin
- ☐ Percodan
- ☐ Topical Anesthetic

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS

- ☐ Heart Murmur
- ☐ Severe/ Frequent Headaches
- ☐ Excessive Thirst
- ☐ High Blood Pressure
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Stroke
- ☐ Alcohol/ Drug Abuse
- ☐ Thyroid Disease
- ☐ Artificial Bone/ Joints
- ☐ Heart Surgery/ Pacemaker
- ☐ Dizziness
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Hepatitis: _____
- ☐ Cancer or Tumors
- ☐ Eating Disorders
- ☐ Leukemia
- ☐ Anemia
- ☐ Emplysema
- ☐ Chest Pains
- ☐ Blurred Vision
- ☐ Sinus Problems
- ☐ Seizures/ Fainting/ Epilepsy
- ☐ HIV/AIDS/ARC
- ☐ Radiation Treatment
- ☐ Asthma
- ☐ Back Problems
- ☐ Scarlet Fever
- ☐ Tuberculosis TB

Do you have or have you had any other disease or medical problem not listed on this form?

◯ Yes ◯ No

If yes, please explain:

Do you have any pre-existing condition that you need to be pre-medicated?

◯ Yes ◯ No

If yes, please list the condition and medication:

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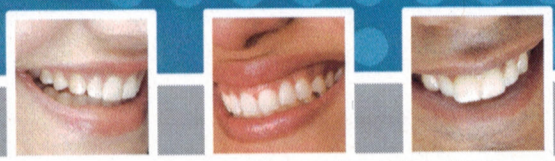

Have you even taken Fosamax, Boniva,Actonel or any other medications containing Bisphosphonate?

◯ Yes ◯ No

Do you take or have you taken Phen-Fen or Redux?

◯ Yes ◯ No

I smoke or use chewing tabacco

☐ Y ☐ N

I have consumed alcohol within the last 24 hours?

☐ Y ☐ N

How did you hear about out office?

☐ Internet ☐ Insurance ☐ Family/Friend ☐ Other

IN EVENT OF EMERGENCY PLEASE CONTACT;

Name Relationship Phone

☐ I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes the medical status. I authorize the dental staff to perform the necessary dental services the patient may need. This office reserves the right to verify the credit status of potential patients or responsible party/guardian of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office is HIPAA Compliant and is committed to meeting or exceeding the standers of infection control mandated by OSHA, the CDC and the ADA.

PLEASE SIGN OUR ELECTRONIC PAD

Doctor's Signature: _____

Response Date: