



Luis Loza, DDS • Jose Loza, DDS • Juan Loza, DDS • Huge Manrique, DDS • Edward Kean, DDS

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (WORK): \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Have you ever had any of the following? Please check those that apply:

- Aids       Cancer       Dizziness       Kidney Disease       Stroke
- Allergies       Epilepsy       Liver Disease       Hay Fever       Tuberculosis
- Anemia       Fainting       Mental Disorder       Heart Disease       Tumors
- Angina       Glaucoma       Nervous Disorder       Heart Attack       Ulcers
- Arteriosclerosis       Growths       Pacemaker       Heart Murmur       Venereal Disease
- Arthritis       Asthma       Head Injuries       Blood Disease       Codeine Allergy
- Diabetes       Jaundice       Hepatitis A B C       Radiation       Seizures
- Sinus Problems       Rheumatism       Stomach Problems       Respiratory Problems       Latex Allergy
- Cardiovascular Disease       High/Low Pressure       Artificial Joints       Local Anesthetic       Penicillin Allergy
- Congenital Heart Lesions       Excessive bleeding       Mitro Valve Prolapse       Rheumatic Fever       Other       Pregnancy Due Date \_\_\_\_\_

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  
 Yes  No if yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?     \_\_\_ Yes     \_\_\_ No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?     \_\_\_ Yes     \_\_\_ No  
If yes, please explain: \_\_\_\_\_
- Do you need to pre-medicate prior to a dental appointment? \_\_\_\_\_  
If yes, which antibiotic? \_\_\_\_\_
- Do you have a persistent cough or cough up blood? \_\_\_\_\_
- What medications are you currently taking on a regular basis? \_\_\_\_\_
- Are you allergic to any medications? \_\_\_\_\_
- Do you use tobacco products? \_\_\_\_\_
- Are you HIV Positive? \_\_\_\_\_

### **Women Only**

- Is there a possibility that you might be pregnant? \_\_\_\_\_
- Are you taking any oral contraceptives? \_\_\_\_\_
- Are you nursing? \_\_\_\_\_

### **Dental History**

- How long since you last dental visit? \_\_\_\_\_
- What was done then? \_\_\_\_\_
- Did you have X-Rays taken? \_\_\_\_\_
- Have you lost any teeth? \_\_\_\_\_
- Are your teeth sensitive to heat? \_\_\_\_\_ Cold? \_\_\_\_\_ Sweets? \_\_\_\_\_ Sour? \_\_\_\_\_
- How often do you brush your teeth? \_\_\_\_\_
- Do you use dental floss? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you have bleeding gums? \_\_\_\_\_ When? \_\_\_\_\_
- Do you grind your teeth? \_\_\_\_\_ When? \_\_\_\_\_
- Have you ever had gum treatments? \_\_\_\_\_ When? \_\_\_\_\_
- Are you aware of any swelling or lump in your mouth? \_\_\_\_\_
- Do you hear popping, clicking, or snapping noises when you chew? \_\_\_\_\_
- Have you had any serious trouble associated with any previous treatments? \_\_\_\_\_  
If so, explain \_\_\_\_\_

**Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.**

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_ **date:** \_\_\_\_\_

**Signature of patient, parent or guardian**

### **Referral Information**

Whom may we thank for referring you to our practice? \_\_\_\_\_

\_\_\_ Yellow Pages \_\_\_ Newspaper \_\_\_ Other

### **Employment Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ EXT: \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### **Insurance Information**

**Insurance Holders Name** \_\_\_\_\_ **Insured Birth Date** \_\_\_\_\_

**Insurance Plans Name and Address**

\_\_\_\_\_  
\_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone # \_\_\_\_\_ Payer ID # \_\_\_\_\_

**Insured's Employer** \_\_\_\_\_

Patient's relationship to the insured? \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

## Spouse or Responsible Party Information

Name: \_\_\_\_\_

SSN# \_\_\_\_\_ Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Doctors Signature: \_\_\_\_\_