sunset smiles dental center

Dr. Luis F. Velásquez, D.D.S.

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Patient Information and Health History

- Name: _____ _____
  (Last name) (Name)
- Address: _____ City _____ State: _____ Zip: _____
- Home phone #: _____ Cell phone #: _____
- E-mail address: _____
- Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____
- Marital Status: ☐ Single ☐ Married ☐ Divorced Occupation: _____
- Who is responsible for this acct?: _____ Relationship with you? _____
- Social Security #: _____
- Dental Insurance Name: _____ ID #: _____
- In case of emergency we must notify: _____
- Phone #: _____
- Who referred you to this office?: _____

Health History

Do you have or have had:

☐ Heart disease
☐ High blood pressure
☐ Low blood pressure
☐ Circulation problems
☐ Nervous system problems
☐ Treatment with Radiation
☐ Artificial heart valves
☐ Defective heart valve
☐ Murmur of the heart
☐ Diabetes
☐ Respiratory Problems
☐ Arthritis
☐ Cancer
☐ Hemophilia
☐ Epilepsy
☐ Headaches
☐ Hepatitis A, B, C or liver problems
☐ Excessive alcohol consumption
☐ Psychiatric care
☐ Recent weight loss
☐ Allergy to anesthesia
☐ Drug Allergies
☐ Allergies in General
☐ Blood disease
☐ Osteoporosis
☐ Rheumatic fever
☐ Sinus Problems
☐ Positive HIV
☐ Thyroid disease
☐ Stroke
☐ Ulcers
☐ Venereal disease
☐ Artificial replacement of joints
☐ Asthma

Have you taken Fosamax or any other medications for bone density? _____
Are you taking any medications at this time? YES ☐ NO ☐ Which ones? _____
Have you ever had any unfavorable reactions in previous dental treatments? _____
For women: Are you pregnant? _____
Are you taking any medication to make the blood thinner? _____

-Known Allergies: YES ☐ NO ☐ Which? _____
-Primary language spoken: Spanish ☐ English ☐ Creole ☐ Other ☐
-Communication assistance is needed: YES ☐ NO ☐

Continue other side ⇨

Dental History:

- Reason why you are visiting the dentist today? _____
- Date of your last dental appointment: _____ X- rays?_____ dental cleaning?: _____
-How many times a day do you brush your teeth? _____
- Do you use dental floss every day?_____ ☐ YES ☐ NO
- Do your gums bleed or hurt when you brush your teeth? _____ ☐ YES ☐ NO
- Do you feel that you have bad breath? _____ ☐ YES ☐ NO
- Are any of your teeth loose? _____ ☐ YES ☐ NO
- Do you have pain in a tooth?: _____ ☐ YES ☐ NO
- Are your teeth sensitive to heat or cold? _____ ☐ YES ☐ NO
- Do you grind your teeth during the day or night? _____ ☐ YES ☐ NO
- Does your jaw jump when you chew? _____ ☐ YES ☐ NO
- Does any food accumulate between your teeth? _____ ☐ YES ☐ NO

FOR PARENTS:

- Does your child suck his fingers or thumb? _____ ☐ YES ☐ NO
- Does your child sleep with a bottle of pacifier? _____ ☐ YES ☐ NO

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information during the diagnosis and records of treatment or examination for myself and my dependents to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any)

_____

Signature of Patient, Parent or Guardian

_____

Date