Patient Information

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

Gender: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for your referral:_____

IN CASE OF EMERGENCY CONTACT:

Name:_____Relationship:_____

Home Phone:(_____)_____ _____ Work Phone_(_____)_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation:_____

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

I certify that I, and/ or my dependent(s) have insurance coverage with the above named company and assigned directly to **Dr. Victoria Tobar** 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 authorize the use of my signature on all insurance submissions. **Dr. Victoria Tobar** may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent Guardian or Personal Representative Date

_____
Relationship to Patient

Dental History

Date of Last Dental Visit: _____ Reason for this visit: _____

Please check those that apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you Floss?

_____

How often do you brush?

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

Health Information

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

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints or heart valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Cortisone treatments
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low blood pressure
- ☐ Mental Disorders
- ☐ Mitral valve prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy/Nursing Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Skin rash
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen feet or ankles
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- 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: _____

List any medications you are currently taking and the correlating diagnosis:

_____

_____Pharmacy:_____

Allergies

Please check those that apply:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: _____

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