Patient Registration and Medical History

(Confidential)

Clara E. Balancio, DDS, Inc. dba
Galvan Dental Care
2809 Redwood Parkway
Vallejo, CA 94591

Date_____

Patient_____ Home# _____
Last Name First Name Middle Cell # _____
Work #_____

E-Mail_____
Address:
Street_____City_____State_____Zip_____
Sex: []M []F Age_____ Birth Date_____ []Single []Married []Divorced []Others_____
Patient Social Security No._____ ID/License No._____State_____
Occupation _____ Employee _____Length of Employment_____
Business Address _____City_____State _____Zip_____
Person Responsible for account: []Self []Parents []Spouse []Guardian []Others_____
Please write name of insurance_____ Group Number_____
Spouse's Name _____ Occupation_____
Office Address _____ Tel. No. _____
In case of emergency, who should be notified? _____ Tel. No. _____
Who may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party _____ Tel. No._____[]Res. []Off.
Occupation:_____ SS# of Responsible party_____
Employer _____ Length of Employment _____
Business Address_____City _____ State_____ Zip _____

DENTAL HISTORY

Reason for visit (Toothache, check-up, etc.) _____
How long since your last visit to the Dentist? _____
Name of former Dentist _____ Tel. No. _____
Reason for change _____
Do you have Dentures? []Yes []No If yes, please check appropriate box:
[]Full Upper []Partial Upper How old?_____
[]Full Lower []Partial Lower How old?_____
Do you have []Crown []Bridges How old? _____
How often do you floss? _____ How often do you brush?_____

Check ☑ if you have had problems with any of the following:

[]Bad breath
[]Bleeding gums
[]Clicking or popping jaw
[]Food collection between teeth
[]Loose teeth or broken fillings
[]Periodontal treatment
[]Sensitive to cold
[]Sensitive to hot
[]Sensitive when biting
[]Sores or growth in your mouth
[]Grinding teeth
[]Sensitive to sweets

TURN OVER AND FILL OUT BACK PAGE, THANK YOU!

Have you had trouble from previous dental care? []Yes []No
Do you have any unhealed injuries or inflamed areas in or around the mouth? []Yes []No
Have you ever had any reaction or allergic symptoms to Novocain, local or general anesthetics? []Yes []No
Have you ever had any difficult extractions in the past? []Yes []No
Have you ever had prolonged bleeding followed extractions in the past? []Yes []No

MEDICAL HISTORY

Certain illnesses and drug may take it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. HAVE YOU EVER HAD OR HAVE THE FOLLOWING: If yes, please check the "YES" box and CIRCLE illness.

		YES	NO
1.	Asthma, hay fever, sinusitis, or other allergies		
2.	Blood pressure or heart problems		
3.	A pacemaker or open heart surgery or heart valve replacement		
4.	Diabetes, liver, kidney, thyroid, or lung problems		
5.	Ulcer or stomach problems		
6.	Hepatitis or Jaundice		
7.	Epilepsy or nervous disorder		
8.	Bleeding or clotting disorder		
9.	Arthritis or hip replacement surgery or prosthetic joint replacement		
10.	Do any wounds heal slowly or present complications?		
11.	Are you presently under the care of a physician? Dr_____ Phone#_____		
12.	When was your last physical exam?		
13.	Have you been hospitalization? Date?		
14.	Have you had X-Ray treatment or chemotherapy?		
15.	Are you presently on a diet or taking supplements?		
16.	Communicable disease? Tuberculosis, Herpes or Venereal?		
17.	Any other illness		
18.	Acquired immune deficiency Syndrome (AIDS)/ A.R.C./HIV Positive		
19.	Are you presently taking any medicine? Specify:		
20.	History of Bisphosphonate(for Osteoporosis) use or treatment? Date:_____		
20.	Women []Are you taking birth control pills? []Are you nursing? []Are you pregnant?		
21.	Check if you have allergies to: []Aspirin []Barbituates []Codeine []local anesthetic []Penicillin []Sulfa []Metal []Latex []Other_____		

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature Date

Doctor's Signature Date