Ricardo Montes De Oca, DMD - Family Dentistry

Date ______________________________

Name ______________________________

Address ______________________________

City ____________ State ______ ZIP__________

Home Phone ____________ Cell ______________

Occupation ____________ Phone ______________

Work Address ______________________________

Social Security No.______________________________

Birthdate ______________ Sex: M ____ F______

Espouse____________ No. Of Children __________

Dental Insurance

1. ______________________________

2. ______________________________

Who Will pay for this account?______________________________

Referred by______________________________

Physician Name______________________________

Physician Address______________________________

Physician Phone No. ______________________________

Reason for visit______________________________

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Medical History

Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to ender 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?:

	Yes	No
1. Asthma, hay fever, sinusitis or other allergies		
2. Allergy to penicilin, aspirin, local or general anesthetic, or other drugs; Specify		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis		
12. Venereal Disease, Herpes		
13. Acquire Immune Deficiency Syndrome (AIDS)		
14. Any other illness		
15. Do any wounds heal slowly or present complications?		
16. Are you presently taking any medicine? Specify		
17.Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized?		
20. Have you had x-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. WOMEN. Are you pregnant?		

Please Complete Reverse Side

Adult Dental History

Date of Last Dental Exam	Date of Last Full Mouth X-Ray	Where Taken

	Yes	No
1. Have you had trouble from previous dental care?		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Nocovain or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction or allergic symptoms to Novocain, local or general anesthetics?		
10.Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you had instructions on the care of your gums?		
15.Do you chew on only one side of your mouth? Is so, Why?		
16. Do you habitually clench or grind your teeth during night or day?		
17.Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)?		
18. Is there any problem not covered above that you would like to discuss?		

Patient or Guardian Signature ________________________ Date ________________________

Update:

Date ________________________ Date ________________________

Signature ________________________ Signature ________________________