Welcome to Rancho Laguna Family Dentistry
24331 El Toro Rd. Suite 340
Laguna Hills, CA 92637

Today's Date:______________________

Patient Information

Name:____Phone:__________________Cell:________________
Last First

Address: ____Apt:_______City:_______________________Zip:_______________

How long in this address:______________________Email:____

Social Security #:___________________________DL #:__________________ Date of Birth:_________________ Sex: ☐ M ☐ F

Are you a student: Y N Guardian Name: ____ Gard SSI #:___________

How did you hear about us? ____

Is there anything we can do to make your visit more comfortable? ____

____

Insurance Information (Primary)

Insurance Company:_______________________________________ Employer:____

Insurance Address:____ Phone #: _______________________

Group Name:____ Group Number:_______________________________________

Subscriber/Member ID: ____________________________________ Relationship: ☐ Self ☐ Spouse ☐ Child

Insurance Information (Secondary)

Insurance Company:_______________________________________ Employer:____

Insurance Address:____ Phone #: _______________________

Group Name:____ Group Number:_______________________________________

Subscriber/Member ID: ____________________________________ Relationship: : ☐ Self ☐ Spouse ☐ Child

Employer Information

Occupation:_______________________________________Employer:__________________________ Work Phone___________

Financial Agreement

- For my convenience, I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me this office may release my information to my insurance.
- Every effort will be made to help me with my insurance. I understand that I am financially responsible for any charges not covered or denied by my insurance.
- I understand that treatment plans may change and I am responsible for all work actually completed.
- I certify that all information provided is accurate, true, and to the best of my knowledge.

____ _____________________

Signature of responsible party or patient
(Parent if patient is a minor)

Date

Dental History

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Dry mouth
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain (popping)
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments
- ☐ Required to take antibiotics prior to dental treatment?

Please share the following dates:

Your last cleaning ______/______

Your last oral cancer screening ______/______

Your last complete set of dental x-rays ______/______

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Name of Previous Dentist:
____

City: ___________________ State: _________________

Phone number: __________________________________

What is the most important thing to you about your future smile and dental health?____
____

On a scale of 1 -10, with 10 being the highest rating:

a) How important is your dental health to you? ____________
b) Where would you rate your current dental health?
c) Dental anxiety or fear? _____

Medical History

- ☐ Anemia
- ☐ Excessive Bleeding (INR > 3)
- ☐ Blood Disease
- ☐ Heart problems or surgery
- ☐ History of infective endocarditis
- ☐ Artificial heart valve, repaired heart defect
- ☐ Pacemaker or implantable defibrillator
- ☐ Stroke (taking blood thinners)
- ☐ Rheumatic or scarlet fever
- ☐ High or Low blood pressure
- ☐ High Cholesterol
- ☐ Allergies (Seasonal)
- ☐ Asthma
- ☐ Emphysema, Shortness of breath
- ☐ COPD – Breathing problems
- ☐ Snoring or sinus problems
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Tuberculosis

- ☐ Diabetes (HbA1c =__________)
- ☐ Digestive disorders
- ☐ Stomach or duodenal ulcer
- ☐ Acid/gastric reflux
- ☐ Celiac disease
- ☐ Crohn''s disease (celiac disease, gastric reflux.
- ☐ Caner (abnormal growth)
- ☐ Radio or Chemotherapy
- ☐ Hepatitis (A,B,C)
- ☐ HIV/AIDS
- ☐ Arthritis/Rheumatoid Arthritis/Lupus
- ☐ Osteoporosis / Osteopenia
  - ☐ Bisphosphonates
  - ☐ Fosamax
  - ☐ Aredia
  - ☐ Phen Fen
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Dizziness/Fainting

- ☐ Artificial joints (date:________________)
- ☐ Herpes (Cold sores)
- ☐ STI/STD
- ☐ Neurological Disorders (ADHD)
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Care
- ☐ Anti depressants
- ☐ Alcohol / Recreational drugs
- ☐ Drug addiction
- ☐ Smoking (all forms)
- ☐ FEMALE – Birth control
- ☐ FEMALE – Pregnant (1st / 2nd / 3rd)
- ☐ MALE – Prostate disorder

Are you allergic to any of the following?

- ☐ Aspirin/Ibuprofen/NSAIDS
- ☐ Acetaminophen
- ☐ Penicillin/Erythromycin
- ☐ Sulfa
- ☐ Metals (gold/silver/copper/nickel)
- ☐ Latex
- ☐ Other:________________________

Are you taking any medication?

Drug:___________________________ Purpose:_____________________
Drug:___________________________ Purpose:_____________________
Drug:___________________________ Purpose:_____________________

Are there any other medical conditions you have that are not listed?
____
____

Name of Physican:____ Specialiy of Physician:_______________________________________

Purpose of recent physical exam?____________________________ Most recent findings?____

Patient (Guardian) Signature: ____**Date**: ____________________

Doctor Signature: ____**Date**: ____________