Rudell Gary S. Jacinto, DMD, Inc.
General and Cosmetic Dentistry
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323-931-1385 Fax No. 323-931-2728

Patient Information

DATE: _____

SS/HIC Patient ID:

Last Name:

First Name: | Middle Initial:

Home# | Work# | Mobile#

Home Address:

City: | State: | Zip code:

Email Address:

Birthdate:

Sex: Male☐ Female☐ | Age:

Married ☐ Widowed ☐ Single ☐ Minor ☐

Separated ☐ Divorced ☐ Partnered for ☐ | Years:

Occupation:

Patient Employer/School:

Employer/School address:

City: | State: | Zip code:

Spouse's name:

Birthdate:

Work Number:

Spouse's Employer:

Who referred you?

IN CASE OF EMERGENCY CONTACT INFORMATION:
(Specify someone who does not live in your household)

Name: | Relationship To patient:

Home: | Work: | Cell:

Dental Insurance

Person responsible for account:

Relationship to Patient:

Insurance Policy #

Group #:

Is patient covered by additional insurance: ☐Yes ☐No

Subscriber's Name:

Birthdate: | SS#

Relationship to patient:

Insurance company:

Assignment & Release:
I certify that I and or my dependent(s) have coverage with:

x _____

And assign directly

Name of insurance company

To doctor:_____ all insurance benefits if any otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date sign below:

X _____
Signature of patient, parent, guardian or personal representative

X _____
Print name of patient, parent, guardian or personal representative

Date | Relationship to Patient

Dental History

Reason for today's visit:

Former Dentist:

City: | State:

Date of last visit:

Date of last dental X-Rays:

Place check "yes or "no" to indicate if you have had any of the following

Foreign objects	Yes☐	No☐	Mouth breathing	Yes ☐	No ☐
Sensitivity to sweets	Yes☐	No☐	Mouth pain when brushing	Yes ☐	No ☐
Sensitivity when biting	Yes☐	No☐	Orthodontic treatment	Yes ☐	No ☐
Sores or growth in your mouth	Yes☐	No☐	Pain around the ears	Yes ☐	No ☐
Chew on one side of mouth	Yes☐	No☐	Periodontal treatment	Yes ☐	No ☐
Cigarette, pipe, or cigar smoking	Yes☐	No☐	Sensitivity to cold	Yes ☐	No ☐
Clicking or popping jaw	Yes☐	No☐	Grinding teeth	Yes ☐	No ☐
Dry Mouth	Yes☐	No☐	Gums swollen or tender	Yes ☐	No ☐
Fingernail biting	Yes☐	No☐	Jaw pain or tiredness	Yes ☐	No ☐
Food Collection between the teeth	Yes☐	No☐	Lip or cheek biting	Yes ☐	No ☐
Sensitivity to heat	Yes☐	No☐	How often do you floss	Yes ☐	No ☐
Bad breath	Yes☐	No☐			
Bleeding gums	Yes☐	No☐			
Blisters on lips or mouth	yes☐	No☐			

Confidential Health History

Patient Name: _____ **Date of Birth:** _____

1. Check appropriate answer (Leave blank if you do not understand the question)

Y☐ N☐ Is your general health good? if no please explain:

Y☐ N☐ Has there been a change in your health within the last year? If yes explain:

Y☐ N☐ Have you gone to the hospital or emergency room or had a serious illness in the last three years? If yes explain:

Y☐ N☐ Are you being treated by a physician now? If yes explain:

Date of last medical exam:		Reason for exam:

Y☐ N☐ Have you had problems with your prior dental treatments? If yes explain:

Date of dental exam:		Name of last treating dentist:

Y☐ N☐ Are you in pain now? If yes explain:

2. Have you experienced any of the following symptoms: (Please check Y or N for each)

Y☐	N☐	Chest pain (Angina)	Y☐	N☐	Blood in stool	Y☐	N☐	Frequent vomiting
Y☐	N☐	Fainting Spells	Y☐	N☐	Diarrhea or Constipation	Y☐	N☐	Jaundice
Y☐	N☐	Significant weight loss	Y☐	N☐	Frequent urination	Y☐	N☐	Dry mouth
Y☐	N☐	Fever	Y☐	N☐	Difficulty urinating	Y☐	N☐	Excessive thirst
Y☐	N☐	Night sweats	Y☐	N☐	Ringing in the ears	Y☐	N☐	Difficulty swallowing
Y☐	N☐	Persistent cough	Y☐	N☐	Headaches	Y☐	N☐	Swollen ankles
Y☐	N☐	Bleeding gums	Y☐	N☐	Blurred vision	Y☐	N☐	Joint pain or stiffness
Y☐	N☐	Blood in urine	Y☐	N☐	Bruise easily	Y☐	N☐	Shortness of breath

3. Have you had or do you have any of the following? (Please check Y or N for each)

Y☐	N☐	Heart disease	Y☐	N☐	AIDS/ HIV	Y☐	N☐	Psychiatric care
Y☐	N☐	Family history of heart disease	Y☐	N☐	Surgeries	Y☐	N☐	Osteoporosis
Y☐	N☐	Heart attack	Y☐	N☐	Hospitalizations	Y☐	N☐	Thyroid disease
Y☐	N☐	Artificial joint(s)	Y☐	N☐	Diabetes	Y☐	N☐	Asthma
Y☐	N☐	Stomach problems or ulcers	Y☐	N☐	Family history of diabetes	Y☐	N☐	Hepatitis
Y☐	N☐	Heart defects	Y☐	N☐	Chemotherapy	Y☐	N☐	Sexually transmitted disease
Y☐	N☐	Heart murmurs	Y☐	N☐	Radiation	Y☐	N☐	Herpes
Y☐	N☐	Rheumatic fever	Y☐	N☐	Arthritis or Rheumatism	Y☐	N☐	Canker or cold sores
Y☐	N☐	Skin disease	Y☐	N☐	Emphysema or lung disease	Y☐	N☐	Anemia
Y☐	N☐	Hardening of arteries	Y☐	N☐	Kidney or bladder disease	Y☐	N☐	Liver disease
Y☐	N☐	High blood pressure	Y☐	N☐	Stroke	Y☐	N☐	Eye disease
Y☐	N☐	Seizures	Y☐	N☐	Eating disorders	Y☐	N☐	Transplant
Y☐	N☐	Cosmetic surgery				Y☐	N☐	Tuberculosis

4. Are you allergic to or have you had a reaction to any of the following (Please check Y or N for each)

Y☐	N☐	Aspirin	Y☐	N☐	Valium	Y☐	N☐	Tetracycline
Y☐	N☐	Darvon	Y☐	N☐	Demerol	Y☐	N☐	Vicodin
Y☐	N☐	Codeine	Y☐	N☐	Penicillin	Y☐	N☐	Percodan
Y☐	N☐	Latex	Y☐	N☐	Food	Y☐	N☐	Nitrous Oxide
Y☐	N☐	Local Anesthetic/ Novocaine / Lidocaine	Y☐	N☐	Erythromycin	Y☐	N☐	Metal

Others:

5. Are you taking or have you taken any of the following in the last three months (Please check Y or N for each)

Y☐	N☐	Recreational Drugs	Y☐	N☐	Tobacco In Any Form	Y☐	N☐	Antibiotics
Y☐	N☐	Over The Counter Medicine	Y☐	N☐	Alcohol	Y☐	N☐	Supplements
Y☐	N☐	Weight Loss Medication	Y☐	N☐	Bisphosphonate (Fosamax)	Y☐	N☐	Aspirin

Please list all prescription Medications: _____

_____

_____

6. All patients (Please check Y or N for each)

Y☐ N☐ Do you have or have you had any other diseases or medical problems not listed on this form? If yes, explain: _____

Y☐ N☐ Have you ever been premedicated for dental treatment? If yes, why? _____

Y☐ N☐ Is there any issue or condition that you would like to discuss with the dentist privately? _____

_____

7. Women section only (Please check Y or N for each)

Y☐ N☐ Are you or could you be pregnant? If yes, what month? _____

Y☐ N☐ Are you nursing? _____

Y☐ N☐ Are you taking birth control pills? _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorized the dentist to contact my physician:

Patient's signature: _____ Date: _____

Physician's name: _____ Phone number: _____

I certify that I have read and understood this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health or medication. Further, I will not hold my dentist or other members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient (parent, or guardian)	**Date**	**Signature of dentist**	**Date**

Medical updates:

I have reviewed my health history and confirm that it accurately states past and present conditions.

Date	**Patient signature**	**Changes to health history**	**Dentist initials**