Patient Information

Sierra Dental Care
3801 Pelandale Ave. Ste. B-9
Modesto, Ca 95356
Phone: (209) 575-2400 Fax: (209) 575-0364
www.Sierradentalcare.com

CH# ___________________

Please Print Clearly

Patient Name	SSN	Todays Date	DOB

Address	City	Zip	Home Phone	Cell Phone

Occupation	Work Phone	E-mail Address

Age	Sex	___Single ____Married	Children	Spouse's Name
	___Male ____Female	___Divorced ___Widowed		

Who referred you to us?	Last Dental Visit	Present Dental Complaint

Primary Insurance Name of Insured (subscriber)	DOB	SSN (Subscriber)	Relationship to patient
			____Self ___Spouse ___Other

Name of Insurance Company	Group Number	Employer

Secondary Insurance Name of Insured (Subscriber)	DOB	SSN (Subsriber)	Relationship to patient
			____Self ____Spouse ____Other

Name of Insurance Company	Group Number	Employer

❑ No Change in information:

Patient Signature (Parent signature if patient is a minor) Date

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Health History & Registration

____
(Patient Name)

Medical Information

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems. **CH#**____________

Do you wear Contact Lenses? .... Yes ❑ No ❑

JOINT REPLACEMENT, Have you had an orthopedic total joint (hip, knee, elbow, finger) Replacement? .... Yes ❑ No ❑
Date:__________, If YES, have you had complications?
List Complications: ____________________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's Disease? Yes ❑ No ❑

Since 2001, were you treated or are you presently, scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or myeloma or metastatic cancer? .... Yes ❑ No ❑
Date treatment began?____________________

ALLERGIES - Are you allergic to or have you had a reaction to:
To all Yes Responses, specify type of Reaction

- Local Anesthetics? __________ Yes ❑ No ❑
- Aspirin? __________ Yes ❑ No ❑
- Penicillin or Other Antibiotics? __________ Yes ❑ No ❑
- Barbiturates, Sedatives or Sleeping Pills? __________ Yes ❑ No ❑
- Sulfa Drugs, Iodine? __________ Yes ❑ No ❑
- Codeine or other Narcotics? __________ Yes ❑ No ❑
- Metals / Latex / Rubber? __________ Yes ❑ No ❑

SUBSTANCE USE - Do you use controlled substances (drugs)? .... Yes ❑ No ❑
Do you use tobacco? (smoking, snuff) .... Yes ❑ No ❑
If Yes, for how long?____________________
Do you drink alcoholic beverages? .... Yes ❑ No ❑
If yes, how much alcohol did you drink in the last 24 Hours?
____
If yes, how much do you typically drink in a week?
____

WOMEN ONLY - Are you:
Pregnant? .... Yes ❑ No ❑
Taking birth control pills or hormonal replacement? .... Yes ❑ No ❑

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

- Artificial (prosthetic) heart valve .... Yes ❑ No ❑
- Previous infective endocarditis .... Yes ❑ No ❑
- Damaged valves in transplanted heart .... Yes ❑ No ❑
- Congenital heart disease (CHD)
  - Unrepaired, cyanotic CHD .... Yes ❑ No ❑
  - Repaired (completely) in last 6 months .... Yes ❑ No ❑
  - Repaired CHD with residual defects .... Yes ❑ No ❑

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

- Cardiovascular Disease .... Yes ❑ No ❑
- Angina .... Yes ❑ No ❑
- Arteriosclerosis .... Yes ❑ No ❑
- Congestive heart failure .... Yes ❑ No ❑
- Damaged heart valves .... Yes ❑ No ❑
- Heart attack .... Yes ❑ No ❑
- Heart murmur .... Yes ❑ No ❑
- Low blood pressure .... Yes ❑ No ❑
- High blood pressure .... Yes ❑ No ❑
- Other congenital heart defects? .... Yes ❑ No ❑

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- Mitral valve prolapse .... Yes ❑ No ❑
- Pacemaker .... Yes ❑ No ❑
- Rheumatic fever .... Yes ❑ No ❑
- Rheumatic heart disease .... Yes ❑ No ❑
- Abnormal bleeding .... Yes ❑ No ❑
- Anemia .... Yes ❑ No ❑
- Blood transfusion – If Yes, date:________ Yes ❑ No ❑
- Hemophilia .... Yes ❑ No ❑
- AIDS of HIV Infection .... Yes ❑ No ❑
- Arthritis .... Yes ❑ No ❑
- Autoimmune disease .... Yes ❑ No ❑
- Rheumatoid arthritis .... Yes ❑ No ❑
- Asthma .... Yes ❑ No ❑
- Bronchitis .... Yes ❑ No ❑
- Emphysema .... Yes ❑ No ❑
- Sinus trouble .... Yes ❑ No ❑
- Tuberculosis .... Yes ❑ No ❑
- Cancer / Chemotherapy / Radiation Treatment .... Yes ❑ No ❑
- Chest pain upon exertion .... Yes ❑ No ❑
- Diabetes Type I or Type II .... Yes ❑ No ❑
- Eating disorder .... Yes ❑ No ❑

- Gastrointestinal disease .... Yes ❑ No ❑
- G.E. Reflux/persistent heartburn .... Yes ❑ No ❑
- Ulcers .... Yes ❑ No ❑
- Thyroid problems .... Yes ❑ No ❑
- Stroke .... Yes ❑ No ❑
- Glaucoma .... Yes ❑ No ❑
- Hepatitis, jaundice or liver disease .... Yes ❑ No ❑
- Epilepsy .... Yes ❑ No ❑
- Fainting Spells or seizures .... Yes ❑ No ❑
- Neurological disorders: If YES specify: .... Yes ❑ No ❑
  ____
- Sleep disorders: .... Yes ❑ No ❑
- Mental health disorder: If YES specify: .... Yes ❑ No ❑
  ____
- Recurrent infections:
  Type of Infection____________________
- Kidney problems .... Yes ❑ No ❑
- Persistent swollen glands in neck .... Yes ❑ No ❑
- Severe headaches / migraines .... Yes ❑ No ❑
- Sexually transmitted disease .... Yes ❑ No ❑

Are you now under the care of a physician? Yes ❑ No ❑

Physician Name:____________________ Phone Number: (______) ____________________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .... Yes ❑ No ❑

Do you have any disease, condition or problem not listed above that you think I should know about? .... Yes ❑ No ❑ If YES, please explain: ____________________

What medications are you currently taking? ____________________

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____
Patient Signature (Parent signature if patient is a minor) Date

FOR COMPLETION BY DENTIST

Comments: ____________________

____________________ Signature:____________________ Date:__________

❑ No Change in information:

Patient Signature (Parent signature if patient is a minor) Date | Dentist Signature Date

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