



# Welcome!

# Modesto Dental Group

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

## Patient Information

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS# \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Birth date \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell ext. \_\_\_\_\_

Married  Widowed  Single  Minor  Separated  Divorced

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_ Birth date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS # Responsible Party \_\_\_\_\_ Driver's License # Resp. Party \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address of employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Tel # ( \_\_\_\_\_ ) \_\_\_\_\_

**DO YOU HAVE ADDITIONAL DENTAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:**

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of employer \_\_\_\_\_

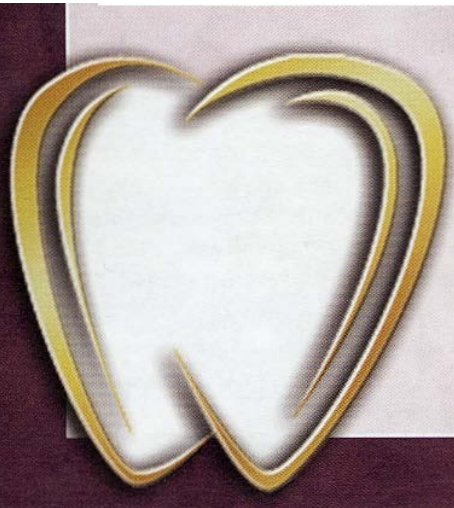
Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ ext. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ Telephone # ( \_\_\_\_\_ ) \_\_\_\_\_



**3025 McHenry Avenue, Suite N Modesto, CA 95350-1449**  
**Tel: (209) 527-3990 Fax: (209) 524-9922**

# Dental History

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date of your last dental exam \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
Reason for today's visit \_\_\_\_\_  
How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

## CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

Yes / No	Bad breath	Yes / No	Grinding teeth	Yes / No	Sensitivity to sweets
Yes / No	Bleeding gums	Yes / No	Loose teeth or broken fillings	Yes / No	Sensitivity when biting
Yes / No	Clicking or popping jaw	Yes / No	Periodontal treatment	Yes / No	Sores or growths in your mouth
Yes / No	Food collection between teeth	Yes / No	Sensitivity to cold		
		Yes / No	Sensitivity to heat		

## Certification and Assignment

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Doctor of Dentistry at the next appointment without fail. I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or X-rays, as may be deemed necessary by the Doctor..

## Assignment of Insurance Benefits

I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to my dependents or myself. I understand that my insurance company may determine that certain procedures performed by dentists are not covered benefit or exceed benefit allowances. Therefore, I accept full financial responsibility for any and all services provided that are not entirely covered by my insurance company. I further agree that any unpaid balance over 60 days will be subject to 1½% per month (18% per annum) finance charge. A photostat of this authorization shall be valid as the original. Also I understand that there will be no charge to reschedule appointments if I give you two of your business days advance notice (Monday-Friday with the exception of holidays). Otherwise I will be subject to a minimum \$50 fee (not payable by the insurance company.) I have received a copy of Modesto Dental Group's office policies.

\_\_\_\_\_  
Signature of patient, parent, guardian, or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of patient, parent, guardian, or personal representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Assistant Signature (Reviewed H.H.)



**CONFIDENTIAL HEALTH HISTORY**

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)**

- 1. Yes / No Is your general health good?  
If NO, explain: \_\_\_\_\_
- 2. Yes / No Has there been a change in your health within the last year?  
If YES, explain: \_\_\_\_\_
- 3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?  
If YES, explain: \_\_\_\_\_
- 4. Yes / No Are you being treated by a physician now? If YES, explain: \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Reason for exam: \_\_\_\_\_
- 5. Yes / No Have you had problems with prior dental treatment?  
If YES, explain: \_\_\_\_\_  
Date of last dental exam: \_\_\_\_\_ Name of last treating dentist: \_\_\_\_\_
- 6. Yes / No Are you in pain now?  
If YES, explain: \_\_\_\_\_

**II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)**

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

**III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)**

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)**

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: \_\_\_\_\_

