Welcome! Suave 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 # _____

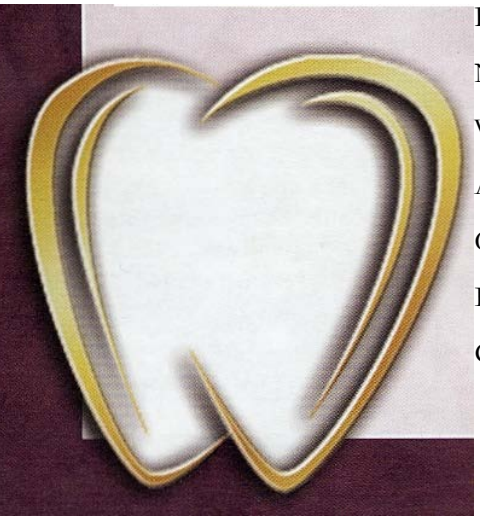
Name of employer _____ Work Phone (____) _____

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 Suave 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: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list medications you are taking_____
_____
_____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:_____
Yes / No Have you ever taken Fen-Phen? If YES, when:_____
Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?** _____
_____

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

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name:_____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her 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 Patient Information and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____