MEDICAL ALERTS

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Dr. Parmar

Family Dentist

Welcome to our office

549 H Street, Suite A, Chula Vista, California, 91910

ACCT.# ____________

Date ____________

PATIENT INFORMATION

Patient Name ______________________ (Last Name) ______________________ (First Name) SS# ____________

Address ______________________ Drivers Lic. # ____________

City ____________ State ______ Zip ______ Home Phone ____________

E-Mail ______________________ Cell Phone ____________

Sex ☐M ☐F Birthdate ____________ Age ______ Marital Status ____________

Patient Employed By ______________________ Occupation ____________

Are you a full/part time student? ☐Yes ☐No Where? ____________

Business Address ______________________ Work Phone ____________

Have any of your family members been into our office? ____________

How were you referred? ☐Patient referral Who may we thank? ____________

☐ Telephone Book ☐Saw Bldg./Sign ☐Internet (Which Site?) ____________

☐ 1-800 Dentist ☐ Dr. Referral ____________ ☐Other ____________

In Case of Emergency, who should be notified? ____________

Relationship ____________ Address ____________ Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ____________ (Last Name) ____________ (First Name) ______ (Initial)

Relationship to Patient ____________ Responsible Person Birthdate ____________

Address (if different from patient's) ____________ Phone ____________

City ____________ State ______ Zip ______

Person Responsible Employed By ____________

Business Address ____________ Bus. Phone ____________

Insurance Company ____________ Insurance Phone ____________

Group # ____________ SS# ____________ ID# ____________

SECONDARY INSURANCE

Is patient covered by additional insurance ____________ ☐Yes ☐No

Subscriber Name ____________ Relationship to Patient ____________ Birthdate ____________

Address (if different from patient's) ____________ SS# ____________

City ____________ State ______ Zip ______ Phone ____________

Subscriber Employed by ____________ Bus. Phone ____________

Insurance Company ____________ Insurance Phone ____________

Group # ____________ SS# ____________ ID # ____________

DENTAL HISTORY

Reason for Today's Visit ______

Former Dentist ______ Phone ______

Date of last dental care ______ Date of last dental x-rays ______

Check (✔) if you have had problems with any of the following:

- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Grinding teeth
- ☐ Periodontal Treatment
- ☐ Sores or growth in mouth
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

Do you wear dentures or partial dentures?______ If so, when were they made?______

Is there any other information we should know about any other dental visits?______

______

MEDICAL HISTORY

Physician's Name ______ Date of Last Visit ______

Have you had any serious illness or operations?______ If yes, describe ______

______

Have you ever had a blood transfusion? ______ if yes, give dates ______

(women) Are you pregnant? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✔) if you have or have had any of the following:

- ○ Aids
- ○ Anemia
- ○ Arthritis, Rheumatism
- ○ Artificial Joints
- ○ Asthma
- ○ Back Problems
- ○ Blood Disease
- ○ Cancer
- ○ Chemical Dependency
- ○ Chemotherapy
- ○ Circulatory Problems
- ○ Cortisone Treatments
- ○ Cough (persistent)
- ○ Cough up blood
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Headaches
- ○ Heart Murmur
- ○ Heart Problems
- ○ Hemophilia
- ○ Hepatitis A or B
- ○ High Blood Pressure
- ○ HIV Positive
- ○ Jaw Pain
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mitral Valve Prolapse
- ○ Nervous Problems
- ○ Pacemaker
- ○ Psychiatric Care
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Shortness of Breath
- ○ Skin Rash
- ○ Stroke
- ○ Swelling of Feet or Ankles
- ○ Thyroid Problems
- ○ Tobacco Habit
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Ulcer
- ○ Venereal Disease

MEDICATIONS

List Medications you are currently taking

______

______ Bone Loss Medication ______

Pharmacy Name ______ Phone ______

ALLERGIES

- ☐ Aspirin
- ☐ Erythromycin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Peniclin
- ☐ Sulfa
- ☐ Latex
- ☐ Other ______

Doctor's Notes______

______

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date______

Signature ______