

If yes, please explain.

DR. ANGELA MENDOZA BAEZ D.D.S.	WELCOME TO	
Cosmetic and Family Dentistry	OUR DENTAL OFFICE	
Date	I.D. #	
	nable us to provide you with the best possible dental care. All information or-patient confidentiality. The dentist will review the questions and ease fill in the entire form. PLEASE PRINT	on
REGISTRATION INFORMATION		
The patient is an: Adult ☐ Child ☐ A Name: Mr./Miss/Mrs./Ms./Dr. Prefers to be called:	Adult under Guardianship Name of Guardian: Language Preference:	_
Home Address:		—
Home Phone:	Cell Phone:	_
E-Mail address: Occupation:	Employer: May we call you at work?	_
Bus. Address:		_
Bus. Phone: E-Mail address:	Ext:	
Date of Birth: D M Y Age	e: Sex:	
Marital Status: Name of	of Spouse:	
Who referred you to our office? Are other family members patients at our office?	? Yes □ No □	
Names:		
MEDICAL PRIORITY		
In case of emergency, we should notify:		
Name:	Relationship:	
Day - Time Phone:	Dharan	
Family Doctor: Medical Specialist:	Phone:Phone:	_
Reason for today's visit? Examination	Emergency Other Other Other Other Other Other Other Other	_
Is there a dental problem you would like treated	d immediately?	_
FINANCIAL INFORMATION		
	Spouse Other Complete all information if different from above	
Name:Address:	Phone:	_
Employed by:		
PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE	
Policy Holder: Date of Birth: D M Y	Policy Holder: Date of Birth: D M Y	
Date of Birth: D M Y Insurance Company:	Date of Birth: DMYInsurance Company:	
Policy # Ins. Yr. end	Policy # Ins. Yr. end	_
Subscriber ID # Relationship of patient to policy holder:	Subscriber ID # Relationship of patient to policy holder:	
Self Spouse Dependant D	Self Spouse Dependant D	
Max. Coverage: \$	Max. Coverage: \$	
% of coverage: Basic Major	% of coverage: Basic Major	
MEDICAL HISTORY Please ☑ YES or	NO to each question.	
	yes on at the present or have you been treated within the past year?	NO
If so, why?		
3. Has there been any change in your general he	ealth in the past year?	
If yes, please explain. 4. Are you taking any medications, non-prescript	otion drugs or herbal supplements of any kind?	
If yes, please list.		_
5. Do you have any allergies? If you answered yes, please list using the cat	tegories helow:	
-A man diantina	tegories below:	
h) latay/wyhhar products		
c) other (e.g. hayfever, foods)		
6. Have you ever had a peculiar or adverse reaction	ction to any medicines or injections?	

7. Do you have or have you ever had asthma? 8. Do you have or have you ever had any heart or blood pressure problems? 9. Do you have or have you ever had an replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? 10. Do you have a prosthetic or artificial joint? 11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? 12. Have you ever had hepatitis, jaundice or liver disease? 13. Do you have a bleeding problem or bleeding disorder? 14. Have you ever been hospitalized for any illnesses or operations? 15. Do you have or have you ever had any of the following? Please check. 15. Do you have or have you ever had any of the following? Please check. 15. Do you have or have you ever had any of the following? Please check. 15. Do you have or have you ever had any of the following? Please check. 16. La chercal problems are included in the problems of breath and the problems of breath and the problems are problems and the problems are problems. 17. Are there any conditions or diseases not listed above that you have or have had? 18. Do you smoke or chew tobacco products? 19. Are you nervous during dental treatment? 20. For women only: Are you breastfeeding or pregnant? 19. If pregnant, what is the expected delivery date? 20. Por women only: Are you breastfeeding or pregnant? 10. If pregnant, what is the expected delivery date? 20. Por women only: Are you breastfeeding or pregnant? 20. How offen do you brush your teeth?	YES	
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How often do you floss your teeth? Please YES or NO to each question. 1. Have you been seeing a dentist regularly? 2. Do any of your teeth ache? 3. Have you ever been advised to take antibiotics before dental appointments? 4. Do your gums bleed when you brush? 5. Do you have any pain when you chew? 6. Do you feel that you have bad breath? 7. Have you ever been in a vehicle accident or experienced any blows to your jaw? 8. Have you ever had any implant surgery in one or both of your jaws or jaw joints? If you answered "yes," to the last question, who performed the surgery and when was it done? Are you being followed up by a dental specialist? Please list anything else not mentioned above regarding your past dental history.	YES	N