Bert F. Engstrom, D.M.D.
David M. Engstrom, D.M.D.
DOCTORS OF DENTAL MEDICANE
1122 Rose Ave., CA 92662 · 559 896-0323

RECORD NO.

DATE: .....

CONFIDENTIAL PATIENT MEDICAL/DENTAL HISTORY

Our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive and maintain. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions.

❑MR
❑MRS
❑ MISS
❑ MS

Name you prefer office staff to use, ❑ First ❑ Last

❑ Other .....

NAME: Last ..... First ..... Middle .....

ADDRESS (City, State, Zip) .....

Home Phone: ( ) ..... Cell: ( ) ..... E-Mail: .....

SS # ..... Drivers License No. ..... Date of Birth: .....

Spouse's Name: ..... Date of Birth: ..... Occupation: ..... Phone: .....

IF YOU ARE COMPLETING THIS FORM FOR A MINOR OR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP? .....

NAME of RESPONSIBLE PERSON: ..... Home Phone: ( ) ..... Occupation: .....

Address: (City, State, Zip) .....

Referred By: ..... **Family Primary Care Doctor:** ..... Phone: ( ) .....

IN CASE OF EMERGENCY: Name: ..... Relationship to Patient: ..... Phone: ( ) .....

PAYMENT PREFERANCE: ❑ Cash ❑ Check ❑ Credit Card (Type) ..... ❑ Insurance ❑ Care Credit ❑ Medical ❑ Other .....

DENTAL INSURANCE INFORMATION

1ST Company: .....

1St Company's Group No: .....

1ST Company's Address: .....

.....

POLICY HOLDER'S NAME .....

Have you met your deducible? ❑ YES ❑ NO

2nd Company: .....

2nd Company's Group No: .....

2nd Company's Address: .....

.....

Policy Holder's Social Security No.: .....

Do you plan to apply for Medi-Cal? ❑ Yes ❑ No

DENTAL HISTORY INFORMATION

Please mark the appropriate box with an X

ADULT DENTAL INFORMATION	Yes	No
Is this your first visit to this office?	❑	❑
Are you currently experiencing dental pain or discomfort ?	❑	❑
Are you nervous about having dentistry treatment?	❑	❑
Have you had any problems associated with previous dental visits?	❑	❑
Do your gums bleed when you brush or floss?	❑	❑
Does food or floss catch between your teeth?	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑
Have you had any periodontal (gum) treatment?	❑	❑

When was your last dental exam? .....

When was your last dental x-rays? .....

What is the reason for your visit? .....

MINOR / CHILDREN DENTAL INFORMATION	Yes	No
Is this you child's first visit to a dentist's office?	❑	❑
Has your child been taught the proper way to brush	❑	❑
How many times a day do they brush ❑ once ❑ twice		
Does someone supervise the brushing/flossing of their teeth?	❑	❑
Has your child had an orthodontic (braces) consultation?	❑	❑

When was your child's last dental exam? .....

When was their last dental x-ray? .....

What is the reason fore their visit? .....

.....

PLEASE COMPLETE AND SIGN BACK SIDE

CONFIDENTIAL PATIENT MEDICAL/DENTAL HISTORY, Continued

HEALTH HESTORY INFORMATION Please mark the appropriate box with an **X**

YES NO

❑ ❑ Have you been under the care of a physician in the past 2 years, if yes, who?

Name: _____ Phone:_____

❑ ❑ Are you allergic to (i.e. itching, rash , swelling of hands, feet or hands) or made sick by penicillin, aspirin, codeine, or any drugs or medications, if yes, what?

_____

YES NO

❑ ❑ Have you had a serious illness, operation or hospitalized in the past 2 years, if yes, what was it for? _____

❑ ❑ Have you taken any medications or drugs during the past 2 years, if yes, what? (list all, including vitamins, herbal and/on diet supplements)

_____

CKECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

YES NO

❑ ❑ Have you ever had any excessive bleeding requiring special treatment?
❑ ❑ When you walk up stairs , do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?
❑ ❑ Do your ankles swell during the day?
❑ ❑ Have you lost or gained more than 10 pounds in the past year?

YES NO

❑ ❑ Do you ever wake up from sleep short of breath?
❑ ❑ Are you on a special diet, if yes what? _____
❑ ❑ Has your doctor ever said you have cancer or tumors?
❑ ❑ WOMEN: (a) Are you pregnant?
❑ ❑ (b) Are you taking birth control, if yes, what? _____

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Heart Failure	❑	❑	Anemia	❑	❑	Thyroid Disease	❑	❑	Yellow Jaundice
❑	❑	Heart Disease	❑	❑	Artificial Joint	❑	❑	X-ray or Cobalt Treatment	❑	❑	Blood Transfusion
❑	❑	Heart Attack	❑	❑	Kidney Trouble	❑	❑	Sickle Cell Disease	❑	❑	Drug Addiction
❑	❑	Angina Pectonis	❑	❑	Ulcers	❑	❑	Heart Mummers	❑	❑	Hemophilia
❑	❑	High Blood Pressure	❑	❑	Emphysema	❑	❑	Rheumatism	❑	❑	Venereal Disease (Syphilis, Gonorrhea)
❑	❑	Rheumatic Fever	❑	❑	Tuberculosis (TB)	❑	❑	Cortisone Medicine	❑	❑	Cold Soars
❑	❑	Congenital Heart Failure	❑	❑	Asthma	❑	❑	Glaucoma	❑	❑	Genital Herpes
❑	❑	Scarlet Fever	❑	❑	Hay Fever	❑	❑	Pain in Joints	❑	❑	Epilepsy or Seizures
❑	❑	Artificial Heart Valve	❑	❑	Sinus Trouble	❑	❑	AIDS	❑	❑	Fainting or Dizzy Spells
❑	❑	Coronary Stent Implant	❑	❑	Allergies	❑	❑	Hepatitis A, (infectious)	❑	❑	Nervousness
❑	❑	Heart Surgery	❑	❑	Hive	❑	❑	Hepatitis B, (serum)	❑	❑	Psychiatric Treatment
❑	❑	Stroke	❑	❑	Latex Allergy	❑	❑	Liver Disease	❑	❑	Chemotherapy (Cancer or Leukemia)
❑	❑	Diabetes	❑	❑	Arthritis	❑	❑	Bruise Easily	❑	❑	Latex Allergy

❑ ❑ Do you have any disease, condition or problem not listed, is yes, what? _____

I understand the need for these questions to be answered truthfully and in my own hand. If I have any changes in my health, or if my medication changes, I will inform the doctor of dentistry at my next appointment

Signature of : ❑ Patient ❑ Parent: ❑ Guardian: _____ Date Signed: _____

I hereby authorize Bert F. Engstrom, D.M.D. and/or David F. Engstrom, D.M.D. and such assistants as required to perform the designated procedures and consent to all such dental treatment as indicated by sound and prudent dental practice. If the use of premedication and/or anesthesia is indicated, I consent to the administration of such premedication and/or anesthesia as the doctor may deem advisable and proper.

Signature of Patient: _____ Signature of Witness: _____

Signature of: ❑ Parent ❑ Guardian _____ Date Signed: _____

Relationship to Patient: _____ Date Medical History Update last completed: _____

NOTES:

_____

_____

_____

_____

1/16/12 _____