CAMBRIDGE DENTAL

——— MARK A. GAONA, D.D.S ———

NEW PATIENT FORM

How did you hear about our office? ____

Name ______________________________ I prefer to be called________________

Address__________________________ _______ City__________ State_____Zip________

Cell Phone__________________ Home Phone____________________

E-mail Address_____________________________

Birthdate ______-______-__________ Age______ Sex______ SS#_______-_______-_______

Marital Status_______ Spouse________________ Number of Children_________

Employer ____________________ Work# ____________ Occupation________________

PERSON RESPONSIBLE FOR ACCOUNT

Name______________________________ Relationship to patient________________

Address__________________________ _______ City__________ State_____Zip________

Cell Phone__________________ Employer____________________

Birthdate ______-______-__________ Sex______ SS#_______-_______-_______

DENTAL INSURANCE

Primary Insurance Company____________________ Ins. Phone #____________________

Claims Address____

Employee__________________ Date of Birth____________ Employer________________

ID #____________________ Group/Policy#______________________________

Secondary Insurance Company____________________ Ins. Phone #____________________

Claims Address____

Employee__________________ Date of Birth____________ Employer________________

ID #____________________ Group/Policy#______________________________

CONSENT: I authorize Mark A. Gaona, D.D.S. to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him to make a diagnosis of my (my child's) dental needs. I understand that consultation with other health professionals may be required to assist with diagnosis of my (my child's) dental conditions. I authorize release of supporting records and information to and from this office for this purpose. I also understand that the use of anesthetic agents embodies a certain risk. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____Date__________________

Signature of Patient, Parent or Guardian

In case of emergency, please contact: ________________________ Phone__________________

GENERAL HEALTH HISTORY

Are you in good health? If no, explain.. YES NO
Are you under a physician's care now?... ………………… YES NO
If yes, please explain .... ……………………..
Name of Physician ....Phone ....

Are you now taking any drugs or medications? .... YES NO
If yes, please list ....

Are you sensitive or allergic to any drugs? .... YES NO
If yes, please list...

Have you been hospitalized in the past two years? .... YES NO
If yes, please explain ....

Do you now have or have you had any of the following?

Condition			Condition		
HIV/AIDS	YES	NO	Herpes	YES	NO
Allergies...	YES	NO	Hepatitis..	YES	NO
Anemia OR Blood Disease……….	YES	NO	High Blood.ressure.......................	YES	NO
Asthma OR Hay Fever……………	YES	NO	Kidney Disease……………… ….	YES	NO
Artificial Joint or Valve…………..	YES	NO	Liver Disease…………………..…	YES	NO
Cancer…………………………….	YES	NO	Radiation Treatment……………..	YES	NO
Diabetes ………………………….	YES	NO	Rheumatic Fever…………………	YES	NO
Epilepsy……………………………	YES	NO	Rheumatism or Arthritis…………	YES	NO
Excessive Bloedmg………………..	YES	NO	Stroke……………………………	YES	NO
Fainting Spells or Seizures…………	YES	NO	Stomach Ulcers…………………	YES	NO
Heart Disease………………………	YES	NO	Tuberculosis……………………..	YES	NO
Heart Murmur………………………	YES	NO	Venereal Disease…………………	YES	NO

Do you have any disease, condition, or problem not listed above?... YES NO
If yes, please explain...
Have you ever been told to pre-medicate with antibiotics before your dental treatment? .... YES NO
WOMEN: Are you pregnant? If yes, due date .... YES NO
Are you taking birth control pills? .... YES NO

DENTAL HISTORY

What is the reason for your visit?...
Date of your last dental treatment………………………………………Last Cleaning…………………
How often do you brush your teeth?...Floss?..
Do your gums bleed, or feel tender or irritated?........... .... YES NO
Are your teeth sensitive to hot, cold, sweets or pressure? .... YES NO
Are you aware of grinding or clenching your teeth? .... YES NO
Do you have headaches, earaches or neck pains? .... YES NO
Are you apprehensive about dental treatment? .... YES NO
Have you ever had a bad reaction to dental anesthetic? .... YES NO
Are you unhappy with the appearance of your teeth? .... YES NO
Does food catch between your teeth? .... YES NO
Have you ever worn braces on your teeth? .... YES NO
Do you wear dentures? .... YES NO
Are you unhappy with your dentures?.. YES NO
Would you like us to help you learn the proper methods of home care, so you can stop dental problems before they start?.. YES NO

The above information is true and I will notify you of any changes.

Signature ____Date________________