PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT REGISTRATION INFORMATION FORMS USING YOUR KEYBOARD AND MOUSE. PLEASE PRINT, SIGN AND THEN MAIL, FAX OR BRING THE FORMS WITH YOU TO YOUR NEXT APPOINTMENT. OUR MAILING ADDRESS IS MOY DENTAL OFFICE, STEPHEN J. MOY DMD, 443 JOAQUIN AVE. SUITE B SAN LEANDRO, CA 94577 OUR PHONE IS (510)351-4030 OUR FAX IS (510)351-5503

IF THIS **APPOINTMENT IS FOR YOU START HERE**

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO. | FAX

CELL | EMAIL

BIRTHDATE | AGE | MALE ☐ | FEMALE ☐

MARRIED ☐ | SINGLE ☐ | DIVORCED ☐ | WIDOWED ☐

SOCIAL SECURITY NO.

IF THIS **APPOINTMENT IS** FOR YOUR CHILD START HERE

DATE

LAST NAME | FIRST | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE ☐ | FEMALE ☐

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO.

ADDRESS

CITY | STATE | ZIP

PHONE NO

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE NO. | FAX NO.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2, Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. 1 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 1 agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ❒YES ❒NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? ❒YES ❒NO
Sweets? ❒YES ❒NO
Biting or Chewing? ❒YES ❒NO
Have you noticed any mouth odors or bad tastes? ❒YES ❒NO
Do you frequently get cold sores, blisters or any other oral lesions? ❒YES ❒NO

Do your gums bleed or hurt? ❒YES ❒NO

Have your parents experienced gum disease or tooth loss? ❒YES ❒NO
Have you noticed any loose teeth or change in your bite? ❒YES ❒NO
Does food tend to become caught in between your teeth? ❒YES ❒NO

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ❒YES ❒NO
Bite your lips or cheeks regularly? ❒YES ❒NO
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ❒YES ❒NO
Mouth breathe while &wake or asleep? ❒YES ❒NO
Have tired jaws, especially in the morning? ❒YES ❒NO
Smoke/chew tobacco? ❒YES ❒NO

Have you ever had:

Orthodontic treatment? ❒YES ❒NO
Oral surgery? ❒YES ❒NO
Periodontal treatment? ❒YES ❒NO
Your teeth ground or the bite adjusted? ❒YES ❒NO
A bite plate or mouth guard? ❒YES ❒NO
A serious injury to the mouth or head? ❒YES ❒NO

If so, please describe, including cause

_____

Have you experienced:

Clicking or popping of the jaw? ❒YES ❒NO
Pain? (joint, ear, side of face) ❒YES ❒NO
Difficulty in opening or closing the mouth? ❒YES ❒NO
Difficulty in chewing on either side of the mouth? ❒YES ❒NO
Headaches, neckaches or shoulder aches? ❒YES ❒NO
Sore muscles (neck, shoulders)? ❒YES ❒NO

Are you satisfied with your teeth's appearance? ❒YES ❒NO

Would you like to keep all of your teeth all of your life? ❒YES ❒NO

Do you feel nervous about having dental treatment? ❒YES ❒NO

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ❒YES ❒NO

If yes, please describe

_____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

_____

_____

1.800.925.2600

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ❒YES ❒NO

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? ❒YES ❒NO

3. Are you taking any medication, drugs or pills now? ❒YES ❒NO

   If yes, please list name and dosage _____

4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ❒YES ❒NO

   If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? ❒YES ❒NO

6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	❒YES ❒NO	Ulcers	❒YES ❒NO	Hepatitis A (infectious) B (serum)	❒YES ❒NO
Chest Pain	❒YES ❒NO	Diabetes	❒YES ❒NO	Venereal Disease	❒YES ❒NO
Congenital Heart Disease	❒YES ❒NO	Thyroid Problems	❒YES ❒NO	A.I.D.S.	❒YES ❒NO
Heart Murmur	❒YES ❒NO	Glaucoma	❒YES ❒NO	H.I.V. Positive	❒YES ❒NO
High Blood Pressure	❒YES ❒NO	Contact lenses	❒YES ❒NO	Cold Sores/Fever Blisters	❒YES ❒NO
Mitral Valve Prolapse	❒YES ❒NO	Emphysema	❒YES ❒NO	Blood Transfusion	❒YES ❒NO
Artificial Heart Valve	❒YES ❒NO	Chronic Cough	❒YES ❒NO	Hemophilia	❒YES ❒NO
Heart Pacemaker	❒YES ❒NO	Tuberculosis	❒YES ❒NO	Sickle Cell Disease	❒YES ❒NO
Rheumatic Fever	❒YES ❒NO	Asthma	❒YES ❒NO	Bruise Easily	❒YES ❒NO
Arthritis/Rheumatism	❒YES ❒NO	Hay Fever	❒YES ❒NO	Liver Disease	❒YES ❒NO
Cortisone Medicine	❒YES ❒NO	Latex Sensitivity	❒YES ❒NO	Yellow Jaundice	❒YES ❒NO
Swollen Ankles	❒YES ❒NO	Allergies or Hives	❒YES ❒NO	Neurological Disorders	❒YES ❒NO
Stroke	❒YES ❒NO	Sinus Trouble	❒YES ❒NO	Epilepsy or Seizures	❒YES ❒NO
Diet (Special/ Restricted)	❒YES ❒NO	Radiation Therapy	❒YES ❒NO	Fainting or Dizzy Spells	❒YES ❒NO
Artificial Joints (hip, knee, etc.)	❒YES ❒NO	Chemotherapy.	❒YES ❒NO	Nervous/Anxious	❒YES ❒NO
Kidney Trouble	❒YES ❒NO	Tumors	❒YES ❒NO	Psychiatric/Psychological Care	❒YES ❒NO

7. Do you use more than two pillows to sleep? ❒YES ❒NO
8. Have you lost or gained more than 1 0 pounds in the past year? ❒YES ❒NO
9. Do you have or have you had any disease, condition, or problem not listed? ❒YES ❒NO

   If yes, please list: _____

10. Women. Are you: **Pregnant?** ❒YES ___ Months ❒NO Nursing? ❒YES ❒NO **Taking birth control pills?** ❒YES ❒NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

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