



PATIENT INFORMATION FORM

WELCOME

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.

- PLEASE FILL OUT THIS FORM COMPLETELY. -

**THE BETTER WE COMMUNICATE,
THE BETTER WE CAN CARE FOR YOU.**

1 ABOUT YOU

Name _____
Preferred Name _____ Male Female
 Single Married Divorced Widowed Separated
Birthdate / / Age _____ SS# _____
Address _____
City _____ State _____ Zip _____
Email _____
Home# _____ Work# _____
Mobile# _____ Fax# _____
Whom may we thank for referring you? _____
Other family members seen by us _____
Last visit date _____
Employer _____
Employer# _____ How long there? _____

2 ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Home# _____ Work# _____
Mobile# _____ Birthdate / /
Email _____
Billing Address _____
City _____ State _____ Zip _____

3 SPOUSE INFO

Name _____
Home# _____ Work# _____
Mobile# _____ Birthdate / /
Email _____

4 INSURANCE

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group# _____
Insured's Name _____ Relation _____
Insured's Birthdate / / Insured's ID# _____
Insured's Employer _____ Insured's Ph# _____

SECONDARY INSURANCE

Provider Name _____
Provider Address _____
City _____ State _____ Zip _____
Group# _____
Insured's Name _____ Relation _____
Insured's Birthdate / / Insured's ID# _____
Insured's Employer _____ Insured's Ph# _____

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5 MEDICAL HISTORY

Your current physical condition Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No

Please list each one _____

Have you ever taken Phen-Fen? Yes No
(Also known as Redux or Pondimin) If yes, when _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Yes No	Abnormal Bleeding	Yes No	Herpes/Fever Blisters
Yes No	Alcohol/Drug Abuse	Yes No	High Blood Pressure
Yes No	Anemia	Yes No	HIV+/AIDS
Yes No	Arthritis	Yes No	Hospitalized (Any Reason)
Yes No	Artificial Bones, Joints or Valves	Yes No	Kidney Problems
Yes No	Asthma	Yes No	Liver Disease
Yes No	Blood Transfusion	Yes No	Low Blood Pressure
Yes No	Cancer/Chemotherapy	Yes No	Lupus
Yes No	Colitis	Yes No	Mitral Valve Prolapse
Yes No	Congenital Heart Defect	Yes No	Pacemaker
Yes No	Diabetes	Yes No	Psychiatric Problems
Yes No	Difficulty Breathing	Yes No	Radiation Treatment
Yes No	Emphysema	Yes No	Rheumatic/Scarlet Fever
Yes No	Epilepsy	Yes No	Seizures
Yes No	Fainting Spells	Yes No	Shingles
Yes No	Frequent Headaches	Yes No	Sickle Cell Disease
Yes No	Glaucoma	Yes No	Sinus Problems
Yes No	Hay Fever	Yes No	Stroke
Yes No	Heart Attack	Yes No	Thyroid Problems
Yes No	Heart Murmur	Yes No	Tuberculosis (TB)
Yes No	Heart Surgery	Yes No	Ulcers
Yes No	Hemophilia	Yes No	Venereal Disease
Yes No	Hepatitis		

Please list any allergies that you have ever had:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Yes No	Aspirin	Yes No	Latex
Yes No	Codeine	Yes No	Penicillin
Yes No	Dental Anesthetics	Yes No	Tetracycline
Yes No	Erythromycin	Yes No	Other
Yes No	Jewelry/Metals		

Please list any medical conditions(s) that you have ever had

6 MEDICAL INFO

Do you have a personal physician? Yes No

Physician's Name _____

Phone# _____ Last Visit Date / /

Are you currently under the care of a physician? Yes No

Please explain _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name _____ Relation _____

Home# _____ Work# _____

7 DENTAL HISTORY

Why have you come to the dentist today? _____

Has your doctor told you that you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is? Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you use floss? _____

How many times a day do you brush? _____

Type of toothbrush bristles? Hard Medium Soft



WELCOME PAGE - Q&A

WE WARMLY WELCOME YOU.

To better serve you, please take just a couple minutes to answer the following questions. Thanks!

Please check any of the following problems that apply to you:

- Sensitivity (hot, cold or sweet)
If so, which teeth
- Headaches, earaches, neck pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, or irritated gums
- Loose, tipped, or shifting teeth
- Bad breath

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

- Dentures
- Partial Dentures
- Periodontal (gum) treatments

Please share the following approximate dates:

Your last cleaning _____

Your last oral cancer screening _____

Your last complete x-rays _____

Who was your previous dentist?

Name: _____

City: _____ State: _____

Phone: _____

What is the most important things to you about your smile and dental health? _____

If you could whiten your teeth, at a cost that anyone could afford, would you like to? Yes No

Do you smoke or use chewing tobacco

- Yes No

If yes, how much? And, for how long?

If you could change your smile, would you:

(Please check all that apply)

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between teeth
- Replace black metal fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 5, with 5 being the highest rating:

(Please circle the numbers that best applies)

How important is your dental health to you?

1 2 3 4 5

How would you rate your current dental health?

1 2 3 4 5

Where do you want your dental health care to be?

1 2 3 4 5

Why did you leave your previous dentist? _____

What is the most important thing to you about your dental visit today? _____



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8 DISCLAIMER

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

In the event that payment in full for charges incurred is not made, I agree to pay off all costs of collection including a 50% collection fee, attorney fees and court costs.

Signature _____

Date _____

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT
UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

9 PRIVACY PRACTICES

Michelle Villanueva, D.D.S.

ACKNOWLEDGEMENT OF NOTICE
OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____, understand that Dr. Villanueva's Office Abides by the HIPAA Law and will protect the privacy of your personal information

Please Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgment.
- Other (Please Specify)

THANK YOU!

We appreciate you for filling out this form completely.
It will allow us to serve you more effectively.

If you have a question at any time, please call us. *We are happy to help.*