SAN CLEMENTE SMILES
BRANDON CURFEW, DMD

Adult Patient Registration & Patient Medical History

Name _____ (Last) _____ (First) _____ (MI) Gender ◯ Male ◯ Female

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Domestic Partner Birthdate _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Email _____ (Please Print)

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Spouse / Additional Contact Information

Name _____ (Last) _____ (First) Birthdate _____

◯ Same Address

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Email _____ (Please Print)

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Primary DENTAL Insurance

Policy Owner Name _____ Policy Owner Soc. Sec # _____

Policy Owner Birthdate _____ Relationship to Patient _____

Policy Owner Employer _____ Insurance Company _____

Group ID # _____ Insurance Phone # _____

Secondary DENTAL Insurance (if applicable)

Policy Owner Name _____ Policy Owner Soc. Sec # _____

Policy Owner Birthdate _____ Relationship to Patient _____

Policy Owner Employer _____ Insurance Company _____

Group ID # _____ Insurance Phone # _____

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Dental History

Reason for seeking dental care at this time? _____

Date of last dental visit? _____ Reason? _____

Former Dentist or current DDS if visiting? _____ City / ST _____

How often do you brush? ◯ Once a day ◯ Twice a day ◯ Three times a day

How often do you floss? ◯ 1 ◯ 2 ◯ 3 ◯ Day ◯ Week ◯ Month

How do you feel about dental treatment? ◯ Relaxed ◯ Uneasy ◯ Anxious ◯ Tense

Have you ever had Nitrous Oxide (laughing gas) during dental treatment? ◯ No ◯ Yes

Have you ever been requested to take antibiotics or other medications before a dental appointment? ◯ No ◯ Yes

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

◯ Aching/Sensitive Teeth
◯ Bleeding Gums
◯ Grinding/Clinching
◯ Cold Sores
◯ Broken Filling
◯ Loose Teeth
◯ Bad Breath
◯ Dry Mouth
◯ Areas of Food Traps
◯ Difficulty Opening
◯ Gum Infection
◯ Oral Surgery
◯ Clicking/Popping Jaw
◯ Jaw Pain
◯ Orthodontics
◯ Periodontal Treatment
◯ None

Check if you could change any of the following about your smile:

◯ Close gaps between teeth
◯ Straighten/even out front teeth
◯ Whiten teeth
◯ Change shape of teeth
◯ Replace missing teeth
◯ None
◯ Other

_____
Please explain

I would be interested in the Doctor giving me an overall comprehensive long term plan for restoring my smile?

◯ Yes ◯ No

Medical History

Physician's Name _____

Are you currently under a physician's care? ◯ Yes ◯ No

If so for what reason? _____

Check the conditions to indicate if you have or have had any of the:

◯ Artificial Heart Valve
◯ Heart Disease
◯ Heart Murmur
◯ Mitral Valve Prolapse
◯ Pacemaker
◯ Heart Surgery
◯ Rheumatic/Scarlet Fever
◯ Artificial Joint
◯ Hepatitus A, B, C
◯ Liver Disease
◯ Kidney Disease
◯ HIV or AIDS
◯ Herpes
◯ High Blood Pressue
◯ Stroke
◯ Cancer
◯ Chemotherapy
◯ Radiation Therapy
◯ Glaucoma
◯ Asthma
◯ Sinus Trouble
◯ Tuerculosis
◯ Diabtes
◯ Epilepsy or Seizures
◯ Fainting/Dizzy Spells
◯ Psychiatric Treatment
◯ Chemical Dependancy
◯ Bleeding Problems
◯ Circulatory Problems
◯ Headaches
◯ Back Problems
◯ None of the above

Continued on next page…

Medical History Continued

Women only, check if you are: ◯ Pregnant ◯ Nursing ◯ Birth Control

Please list drugs, medications or injections taken in the last 3 months:

_____ _____

_____ _____

_____ _____

List Allergies: ◯ Aspirin ◯ Latex ◯ Sulfa ◯ Codeine ◯ Penicill ◯ No

List any other allergies:

_____ _____

_____ _____

Have you ever taken Fen-Phen? ◯ Yes ◯ No

Do you use cigarettes and/or tobacco? ◯ Yes ◯ No

Do you use or do you have a history of using illegal drugs? ◯ Yes ◯ No

How often do you consume alcohol? ◯ Never ◯ Occasionally ◯ Weekly ◯ Daily

Would you like to speak to the Doctor privately about any concerns? ◯ Yes ◯ No

How did you hear about our office ◯ Google (Reviews) ◯ Yelp (Reviews) ◯ Media Ad

◯ Other _____

◯ Friend/Family/Patient _____

I understand that the information I have provided is correct to the best of my knowledge, that it 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 hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand financial arrangements must be made in advance. I am personally responsible for payment of all fees for dental services in this office regardless of insurance coverage. Payment is due when services are rendered. All emergency services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

Acceptance of Terms ◯ I have read and accept the above conditions

_____

Patient Signature Date

_____

Doctor Signature Date