OAK VALLEY
FAMILY DENTAL

951-769-7797

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Date _____

PATIENT INFORMATION

Name_____ Birth date_____ SS#_____

Address_____ City_____ State_____ Zip _____

Sex □ M □ F □ Married □ Widowed □ Single □Minor
□ Separated □Divorced □ Partnered

Home # ( )_____ Cell # ( )_____ Work # ( )_____

Employer _____ Employer Phone ( )_____

Employer Address_____ City_____ State_____ Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone ( )_____

Whom may we thank for referring you? _____

Person to contact in case of emergency? _____ Phone ( )_____

RESPONSIBLE PARTY

Name of person
Responsible for this account_____ Relation to Patient_____

Address_____ Home Phone ( )_____

Birth date_____ Currently a patient in our office □ Yes □ No

Employer_____ Work Phone ( )_____

E-Mail_____ Cell Phone ( )_____

INSURANCE INFORMATION

Name of Insured_____ Relation to Patient_____

Birth date_____ SS#_____ Date Employed_____

Employer_____ Work Phone ( )_____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient_____

Birth date_____ SS# _____ Date Employed_____

Employer _____ Work Phone ( )_____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), and Redux (dexfenfluramine). □ Yes □ No

Have you ever had any serious illnesses or operations?? □ Yes □ No If yes, describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes give approximate dates _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (x) if you have or have had problems with any of the following:

□ **Anemia**	□ **Congenital Heart lesions**	□ **Hepititis**	□ **Scarlet Fever**
□ **Arthritis, Rheumatism**	□ **Cortisone Treatments**	□ **Hernia Repair**	□ **Shortness of Breath**
□ **Artificial Heart Valves**	□ **Cough, Persistent**	□ **High Blood Pressure**	□ **Skin Rash**
□**Artificial Joints, Pins, ect.**	□ **Cough up Blood**	□ **HIV/AIDS**	□ **Stroke**
□**Asthma**	□ **Diabetes**	□ **Jaw Pain**	□ **Swelling of Feet/Ankles**
□ **Back Problems**	□ **Epilepsy**	□ **Kidney Disease**	□ **Thyroid Problems**
□ **Bleeding Abnormally**	□ **Fainting**	□ **Liver Disease**	□ **Tobacco Habit**
□ **Blood Disease**	□ **Glaucoma**	□ **Mitral Valve Prolapse**	□ **Tonsillitis**
□ **Cancer**	□ **Headaches**	□ **Pacemaker**	□ **Tuberculosis**
□ **Chemical Dependency**	□ **Heart Murmur**	□ **Radiation Treatment**	□ **Ulcer**
□ **Chemotherapy**	□ **Heart Problems**	□ **Respiratory Disease**	□ **Venereal Disease**
□ **Circulatory Problems**	□ **Hemophilia**	□ **Rheumatic Fever**	

List medications you are currently taking:

_____ _____

_____ _____

Allergies:

□ Aspirin	□ Local Anesthetic	□ Iodine	□ Other _____
□ Barbiturates (Sleeping Pills)	□ Penicillin	□ Latex	_____
□ Codeine	□ Sulfa	□ None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relation to Patient

PATIENT ACKNOWLEDEMENT
of
Dental Material Fact sheet and HIPAA Privacy Policy

I, _____, acknowledge that I have received from Oak Valley Family Dental, a copy of the Dental Materials Fact Sheet dated October 2001 and the HIPPA Privacy Policy.

Patient/Guardian Signature **Date**

Recare Updates:

_____ _____

_____ _____

_____ _____