INDIO FAMILY DENTAL CARE
82013 Dr Carreon Blvd, Ste D
Indio, California 92201 **760.775.0087**

Welcome to our office. Please print your answers to the following questions in order to assist us to help you. Your information is private and protected.

Name _____
Birth date _____ SS No _____
Mailing address _____
City_____ State _____ ZIP _____
Phone (home) _____ (Cell) _____
Email address _____
Employer _____ Phone _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (If self, skip to next section)

Name _____
Birth date _____ SS No _____
Mailing address _____
City_____ State _____ ZIP _____
Phone (home) _____ (Cell) _____
Email address _____
Employer _____ Phone _____

PRIMARY DENTAL INSURANCE

Insured Name _____ Ins. Name _____
Birth date _____ SS No _____ Ins. Address _____
Employer _____ City_____ State_____ ZIP _____
Emp. Address _____ Ins. Phone _____ Ext. ____
City _____ State _____ ZIP _____ Group No. _____ Plan _____

SECONDARY DENTAL INSURANCE

Insured Name _____ Ins. Name _____
Birth date _____ SS No _____ Ins. Address _____
Employer _____ City_____ State_____ ZIP _____
Emp. Address _____ Ins. Phone _____ Ext. _____
City _____ State _____ ZIP _____ Group No. _____ Plan _____

EMERGENCY CONTACT

Name _____
Relation _____ **Phone** _____
Physician _____ **Phone** _____

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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	Yes	No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	_____
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

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

AIDS/HIV positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatment	Yes No
Alzheimer's disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No _____

Comments : _____

_____

Medications:

Please list any medications you are currently taking: _____

_____

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DENTAL INFORMATION

What is your main concern with your teeth? _____

(Please circle where applicable)

Bad breath or taste	Sensitive teeth	Clenching or grinding
Bleeding gums	Pain around ear	Frequent headaches
Difficulty chewing food	Dry mouth	Other

Long-term goals _____

Any trouble with previous dental treatment? _____

ORAL HYGIENE: what do you use?

Toothbrush	Floss	Interdental stimulators
Automatic toothbrush	Toothpicks	Water jet device
Fluoride supplements or gels	Other	

FEAR: please indicate (0=none, 1=mild, 2=moderate, 3=severe, 4=disabling panic)

Calling for an appointment	Sitting in dental chair	Having an injection
Waiting in the reception room	Having teeth x-rayed	Having teeth drilled
Smell of dental office	Seeing dental instruments	Having an extraction
Seeing the dentist	Having a cleaning	Losing control

Authorization

I authorize my dentist and his designated staff to perform an oral examination for the purpose of diagnosis and treatment planning including the taking of all xrays as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

FEES & PATMENTS

I understand an estimate of the charge for any procedure I may require will be given to me upon request. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that dental insurance is a method of reimbursement for fees paid to the doctor, and my insurance carrier may pay less than the actual bill for services.

SIGNATURE ON FILE

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor of the benefits otherwise payable to me.

Signature (parent or guardian, if minor) _____ Date _____

Witness name _____

Signature _____ Date _____