ELITE DENTAL CARE

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Tracy ,Ca 95304
www.theelitedental.com

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Welcome to Elite Dental Care

First Name | Middle Initial | Last Name | Date

Birthdate | Responsible Party, if patient is a minor | Relationship to patient

Social Security No. | Email Address

GENDER ◯ Male ◯ Female **MARITAL STATUS** ◯ Minor ◯ Single ◯ Married/Partnered ◯ Widowed ◯ Divorced/Separated

Street Address | City | State | Zip Code

Home Phone | Cell Phone

Employer | Business Phone | Ext | Occupation

Business Street Address | City | State | Zip Code

How did you hear about us?

◯ _____
Referred By | Relationship

◯ Yelp ◯ Google ◯ ZocDoc ◯ Other

Emergency Contact Information

Contact Name

Phone | Relationship

INSURANCE

PRIMARY INSURANCE

Insured Member | Relationship

Birthdate | Employer | Telephone

Insurance Company | Subscriber ID No. | Group No. | Social Security No.

SECONDARY INSURANCE

Insured Member | Relationship

Birthdate | Employer | Telephone

Insurance Company | Subscriber ID No. | Group No. | Social Security No.

MEDICAL INSURANCE

Insured Member | Relationship

Birthdate | Employer | Telephone

Insurance Company | Subscriber ID No. | Group No. | Social Security No.

CONTINUE ▶

DENTAL HISTORY

Reason for today's visit

Former Dentist

City State

Date of last visit Date of last x-rays

How often do you floss? How often do you brush?

Y N Bleeding Gums
Y N Burning Sensation on Tongue
Y N Chewing on one side of Mouth
Y N Fingernail Biting
Y N Food Collection between Teeth
Y N Frequent Headaches
Y N Grinding Teeth
Y N Gums Swollen or Tender
Y N Jaw Difficulty, Clicking and/or Pain
Y N Jaw, Head, or Neck Injuries

Y N Loose Teeth or Broken Fillings
Y N Orthodontic Treatment
Y N Pain Around Ear
Y N Periodontal Treatment
Y N Sensitivity to Cold
Y N Sensitivity to Heat
Y N Sensitivity to Sweets
Y N Sensitivity when Biting
Y N Sores or Growths in Your Mouth
Y N Tooth Pain

MEDICAL HISTORY

Medical Doctor

Hospital Affiliation

City State Last Visit

Y N Currently under medical treatment
Y N Smoke, frequency: _____
Y N Alcohol Use
Y N Recreational drug use
Y N Serious illnesses or operations:

Medications

Pharmacy Telephone

Allergies

Y N Penicillin/Antibiotics
Y N Sulfa Drugs
Y N Barbiturates
Y N Sedatives
Y N Iodine
Y N Latex
Y N Metals

Other

Y N AIDS
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artifical Heart Valves
Y N Artificial Joints
Y N Asthma
Y N Back Problems
Y N Bleeding abnormally, with extractions or surgery
Y N Blood Disease
Y N Cancer
Y N Chemical Dependency
Y N Chemotherapy
Y N Chronic Fatigue Syndrome
Y N Circulatory Problems
Y N Congenital Heart Lesions
Y N Cortisone Treatments
Y N Cough (persistent or bloody)
Y N Diabetes
Y N Emphysema
Y N Epilepsy
Y N Fainting or Dizziness
Y N Glaucoma
Y N Headaches
Y N Heart Murmur
Y N Heart Problems
Y N Hepatitis, Type_____
Y N Herpes, Type_____
Y N High Blood Pressure
Y N HIV Positive
Y N Jaundice
Y N Jaw Pain
Y N Kidney Disease

Y N Latex Sensitivity
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Nervous Problems
Y N Pacemaker
Y N Psychiatric Care
Y N Radiation Treatment
Y N Respiratory Disease
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Shortness of Breath
Y N Sinus Trouble
Y N Skin Rash
Y N Stroke, Date _____
Y N Swelling of Feet/Ankles
Y N Swollen Neck Glands
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis
Y N Tumor or Growth on Head/ Neck
Y N Ulcer
Y N Venereal Disease
Other

Women Only

Y N Pregnant, Due Date: _____
Y N Nursing
Y N Using Birth-Control Pills

Office Use Only _____ _____
Doctor Date

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Elite Dental Care for all insurance bene ts otherwise payable to me for services rendered. I understand that I am nancially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above practice and/ or any provider or supplier of services in this o ce to release this information required to secure the payment of bene ts. I authorize the use of this signature on all insurance.

Signature of Responsible Party

Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS