Carol L. Daderian, D.D.S.

32272-C Camino Capistrano San Juan Capistrano, Ca. 92675 (949) 661-3594

NAME _____ **DATE OF BIRTH** _____

HEALTH HISTORY

Are you in good health? ..... Yes ___ No ___

Are you having dental pain or discomfort at this time?..... ...

Have you been a patient in the hospital during the last two years?..... Yes ___ No ___

If so, what for? _____

Are you under the care of a physician? ..... Yes ___ No ___

If so, what are you being treated for? _____

Are you now taking any medications or over-the-counter drugs?.....Yes ___ No ___

If so, please list: _____

Are you sensitive or allergic to any medications or anesthetics?.....Yes ___ No ___

If so, please list: _____

Have you had problems with prior dental treatments?.....Yes ___ No ___

If so, what happened? _____

Have you ever taken Fen-Phen, Redux, Pondimin?.....Yes ___ No ___

If yes, when? _____

Have you been exposed to the HIV virus or AIDS?.....Yes ___ No ___

Have you ever had gum treatment/surgery?.....Yes ___ No ___

If yes, when? _____

Please list any other diseases or medical problems not listed on this form _____

_____

For women: Are you pregnant?.....Yes ___ No ___

If yes, what month? _____

For women: Are you taking birth control pills?.....Yes ___ No ___

For women: Have you reached menopause?.....Yes ___ No ___

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...

	Yes	No		Yes	No
Rheumatic fever			Diabetes		
Heart Disease			Parkinson's disease		
Heart Attack			Alzheimer's		
Mitral Valve Prolapse			Developmentally disabled		
Heart murmur (irregular beat)			Thyroid problems		
Cardiac pacemaker			Kidney problems		
High/Low blood pressure			Sinus trouble		
Hepatitis A, B, or C			Allergies/Hay fever		
Artificial joints (hip, knee, etc.)			Ulcers		
Stroke			Glaucoma		
Cancer			Chronic fatigue		
Radiation or Chemotherapy			Bronchitis/Chronic cough		
Dialysis			Headaches		
Emphysema			Epilepsy/Seizures		
Asthma			Dizzy spells/Fainting		
Tuberculosis			Treated for nervousness		
Cold sores/Fever blisters			Allergy to latex		
Contagious diseases			Drug/Alcohol addiction		
Sexually Transmitted Diseases			Tobacco dependency		
Blood transfusion			Removable dental appliance		
Anemia			Pain/Clicking of jaw		
Hypoglycemia			Bruise easily		
Bleed easily			Supplements or herbs		

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NAME _____

Patient Complaint: Please indicate all that apply:

Bleeding gums _____
Bad taste or breath odor _____
Tooth sensitivity to hot, cold, bite or sweet _____
Loose teeth _____
Clench or grind teeth _____
Orthodontic treatment currently or in the past _____
How long since your last full mouth set of x-rays? _____
How long since your last dental treatment? _____

CONSENT

* I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
* I have answered all questions truthfully and to the best of my knowledge.
* The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
* I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____.
* I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
* I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.
* I also understand it is my responsibility to know and understand my dental benefits, and not the responsibility of the dental office.
* In the event payments are not received by the agreed upon dates, I understand that a 1 1/2 % finance chare (18% APR) may be added to my account, in addition to any collection charges.
* I understand that it is my responsibility to advise your office of any changes in the information contained on the form, including the previous pages.

Signature _____ **Date** _____

HEALTH HISTORY UPDATES

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____