



CLOVIS FAMILY DENTISTRY

Personal Information	
Email Address	
Last Name	
First Name	
Middle Initial	
Title	<input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Ms. <input type="radio"/> Dr.
I prefer to be called	
Sex	<input type="radio"/> Male <input type="radio"/> Female
Birthdate	__/__/__
Social Security Number	
Driver's License Number	
Marital Status	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Partnered <input type="radio"/> Divorced / Separated <input type="radio"/> Widowed

Home Address	
Address	
Apartment	
Condo	
City	
State	
Zip	

Telephone	
Cell	
Home	
Work	
Extension	
Direct Line	

Employer	
Name	
Address	
City	
State	
Zip	
How long there?	
Occupation	

Additional Information	
Where & when are best times to reach you?	
Whom may we thank for referring you?	
Other family members seen by us	
Name of Previous Dentist	
Person Responsible for Account	

Spouse Personal Information	
Name	
Employer	
Social Security Number	
Birthdate	__/__/__

Spouse Telephone	
Work	
Extension	
Direct Line	

Emergency Contact	
Name	
Relation	
Work Phone Number	
Home Phone Number	

Insurance Information	
Dental Coverage	<input type="radio"/> Yes <input type="radio"/> No
Company Name	
Address	
City	
State	
Zip	
Phone Number	

Insured Party	
Group, Plan, Local or Policy Number	
Name	
Relation	
Birthdate	__/__/__
Social Security Number	
Employer Name	
Employer Address	
Employer City	
Employer State	
Employer Zip	

Medical History	
Personal physician	<input type="radio"/> Yes <input type="radio"/> No
Name	
Phone Number	
Last Visit Date	__/__/__
Your current physical health	<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor

Are you currently under the care of a physician?	<input type="radio"/> Yes <input type="radio"/> No
Please explain	

Do you smoke or use tobacco in any other form?	<input type="radio"/> Yes <input type="radio"/> No
Have you had any metal rods, pins or implants?	<input type="radio"/> Yes <input type="radio"/> No
Are you taking prescription / over-the-counter drugs?	<input type="radio"/> Yes <input type="radio"/> No
Please list each one	

Have you ever taken Phen-Fen / Redux / Pandimin?	<input type="radio"/> Yes <input type="radio"/> No
If so, when?	
Have you taken or do you take Bisphosphonates now (e.g. Aredia, Actonel, Boniva, Fosamax, Zometa)	<input type="radio"/> Yes <input type="radio"/> No

Women Only	
Are you using a prescribed method of birth control?	<input type="radio"/> Yes <input type="radio"/> No
Are you pregnant?	<input type="radio"/> Yes <input type="radio"/> No
Number of weeks	
Are you nursing?	<input type="radio"/> Yes <input type="radio"/> No



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Have you had any of the following diseases / medical problems?

Abnormal Bleeding / Hemophilia	<input type="radio"/> Yes <input type="radio"/> No
AIDS	<input type="radio"/> Yes <input type="radio"/> No
Alcohol / Drug Abuse	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Artificial Bones / Joints / Valves	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No
Cancer / Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No
Colitis	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Defect	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Difficulty Breathing	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy	<input type="radio"/> Yes <input type="radio"/> No
Fainting Spells	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Hay Fever	<input type="radio"/> Yes <input type="radio"/> No
Heart Attack / Heart Surgery	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis	<input type="radio"/> Yes <input type="radio"/> No
Herpes / Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
HIV +	<input type="radio"/> Yes <input type="radio"/> No
Hospitalized for Any Reason	<input type="radio"/> Yes <input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Pacemaker	<input type="radio"/> Yes <input type="radio"/> No
Psychiatric Problems	<input type="radio"/> Yes <input type="radio"/> No
Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic / Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Seizures	<input type="radio"/> Yes <input type="radio"/> No
Shingles	<input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease / Traits	<input type="radio"/> Yes <input type="radio"/> No
Sinus Problems	<input type="radio"/> Yes <input type="radio"/> No
Stroke	<input type="radio"/> Yes <input type="radio"/> No
Thyroid Problems	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis (TB)	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No

Please list any serious medical condition(s) that you have ever had

Are you allergic to any of the following?

Aspirin	<input type="radio"/> Yes <input type="radio"/> No
Erythromycin	<input type="radio"/> Yes <input type="radio"/> No
Penicillin	<input type="radio"/> Yes <input type="radio"/> No
Codeine	<input type="radio"/> Yes <input type="radio"/> No
Jewelry/Metals	<input type="radio"/> Yes <input type="radio"/> No
Tetracycline	<input type="radio"/> Yes <input type="radio"/> No
Dental Anesthetics	<input type="radio"/> Yes <input type="radio"/> No
Latex	<input type="radio"/> Yes <input type="radio"/> No
Other	<input type="radio"/> Yes <input type="radio"/> No

Please list any other drugs / materials that you are allergic to

Dental History

Why are you coming to the dentist today?	
Are you currently in pain?	<input type="radio"/> Yes <input type="radio"/> No
Do you require antibiotics before dental treatment?	<input type="radio"/> Yes <input type="radio"/> No
Your current dental health	<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
Have you ever had a serious / difficult problem associated with previous dental work?	<input type="radio"/> Yes <input type="radio"/> No
Do you floss daily?	<input type="radio"/> Yes <input type="radio"/> No
Do you brush daily?	<input type="radio"/> Yes <input type="radio"/> No
Type of bristles on your toothbrush?	<input type="radio"/> Hard <input type="radio"/> Medium <input type="radio"/> Soft
Have you ever had gum treatment?	<input type="radio"/> Yes <input type="radio"/> No
Do your gums ever bleed?	<input type="radio"/> Yes <input type="radio"/> No
Do your gums ever itch?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever had periodontal disease?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?	<input type="radio"/> Yes <input type="radio"/> No
Are your teeth sensitive to heat, cold, or anything else?	
Do you have any loose teeth?	<input type="radio"/> Yes <input type="radio"/> No
Do you still have wisdom teeth?	<input type="radio"/> Yes <input type="radio"/> No
Would you like fresher breath?	<input type="radio"/> Yes <input type="radio"/> No
Would you like whiter teeth?	<input type="radio"/> Yes <input type="radio"/> No
Are you happy with the way your smile looks?	<input type="radio"/> Yes <input type="radio"/> No
If not, what would you change?	

Terms and Conditions

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Please note that we require at least TWO business days to change your appointment.

I acknowledge and agree to be charged for no show appointments.

Patient Signature