CLOVIS FAMILY DENTISTRY

Personal Information	
Email Address	
Last Name	
First Name	
Middle Initial	
Title	◯ Mr. ◯ Mrs. ◯ Ms. ◯ Dr.
I prefer to be called	
Sex	◯ Male ◯ Female
Birthdate	
Social Security Number	
Driver's License Number	
Marital Status	◯ Single ◯ Married ◯ Partnered ◯ Divorced / Separated ◯ 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	◯ Yes ◯ 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	◯ Yes ◯ No
Name	
Phone Number	
Last Visit Date	
Your current physical health	◯ Good ◯ Fair ◯ Poor
Are you currently under the care of a physician?	◯ Yes ◯ No
Please explain	
Do you smoke or use tobacco in any other form?	◯ Yes ◯ No
Have you had any metal rods, pins or implants?	◯ Yes ◯ No
Are you taking prescription / over-the-counter drugs?	◯ Yes ◯ No
Please list each one	
Have you ever taken Phen-Fen / Redux / Pandimin?	◯ Yes ◯ No
If so, when?	
Have you taken or do you take Bisphosphonates now (e.g. Aredia, Actonel, Boniva, Fosamax, Zometa)	◯ Yes ◯ No

Women Only	
Are you using a prescribed method of birth control?	◯ Yes ◯ No
Are you pregnant?	◯ Yes ◯ No
Number of weeks	
Are you nursing?	◯ Yes ◯ No

Office: (559)840-4330 | Clovis Family Dentistry | 1795 Herndon Ave Suite 104 | Clovis, CA 93611 | ClovisDentistry@gmail.com

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Have you had any of the following diseases / medical problems?	
Abnormal Bleeding / Hemophilia	◯ Yes ◯ No
AIDS	◯ Yes ◯ No
Alcohol / Drug Abuse	◯ Yes ◯ No
Anemia	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No
Artificial Bones / Joints / Valves	◯ Yes ◯ No
Asthma	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No
Cancer / Chemotherapy	◯ Yes ◯ No
Colitis	◯ Yes ◯ No
Congenital Heart Defect	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No
Difficulty Breathing	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No
Epilepsy	◯ Yes ◯ No
Fainting Spells	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No
Heart Attack / Heart Surgery	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No
Hepatitis	◯ Yes ◯ No
Herpes / Fever Blisters	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No
HIV +	◯ Yes ◯ No
Hospitalized for Any Reason	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No
Lupus	◯ Yes ◯ No
Mitral Valve Prelapse	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No
Psychiatric Problems	◯ Yes ◯ No
Radiation Treatment	◯ Yes ◯ No
Rheumatic / Scarlet Fever	◯ Yes ◯ No
Seizures	◯ Yes ◯ No
Shingles	◯ Yes ◯ No
Sickle Cell Disease / Traits	◯ Yes ◯ No
Sinus Problems	◯ Yes ◯ No
Stroke	◯ Yes ◯ No
Thyroid Problems	◯ Yes ◯ No
Tuberculosis (TB)	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No
Venereal Disease	◯ Yes ◯ No
If you answered yes to any of the above, please comment	
Please list any serious medical condition(s) that you have ever had	

Are you allergic to any of the following?	
Aspirin	◯ Yes ◯ No
Erythromycin	◯ Yes ◯ No
Penicillin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No
Jewelry/Metals	◯ Yes ◯ No
Tetracycline	◯ Yes ◯ No
Dental Anesthetics	◯ Yes ◯ No
Latex	◯ Yes ◯ No
Other	◯ Yes ◯ 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?	◯ Yes ◯ No
Do you require antibiotics before dental treatment?	◯ Yes ◯ No
Your current dental health	◯ Good ◯ Fair ◯ Poor
Have you ever had a serious / difficult problem associated with previous dental work?	◯ Yes ◯ No
Do you floss daily?	◯ Yes ◯ No
Do you brush daily?	◯ Yes ◯ No
Type of bristles on your toothbrush?	◯ Hard ◯ Medium ◯ Soft
Have you ever had gum treatment?	◯ Yes ◯ No
Do your gums ever bleed?	◯ Yes ◯ No
Do your gums ever itch?	◯ Yes ◯ No
Have you ever had periodontal disease?	◯ Yes ◯ No
Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?	◯ Yes ◯ No
Are your teeth sensitive to heat, cold, or anything else?	
Do you have any loose teeth?	◯ Yes ◯ No
Do you still have wisdom teeth?	◯ Yes ◯ No
Would you like fresher breath?	◯ Yes ◯ No
Would you like whiter teeth?	◯ Yes ◯ No
Are you happy with the way your smile looks?	◯ Yes ◯ No
If not, what would you change?	
Dentist note	

Patient signature

Date

Terms and Conditons

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.

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