Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Bruce M. Rogers, D.D.S., 19621 Yorba Linda Blvd., Yorba Linda, CA 92886, (714) 970-6331

About You

Today's Date: ____________________ E-mail Address: ____________________

Name: ____________________ I prefer to be called: ____________________ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: ______ Social Security #: ____________________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: ____________________
Street City State Zip

Home Phone #: (_____)__________ Cell/other #: (_____)__________ Work Phone #: (_____)__________ Ext: ______

Where & when are best times to reach you? ____________________ Whom may we thank for referring you? ____________________

Other family members seen by us: ____________________

Employer: ____________________ How long there? __________ Occupation: ____________________

Employer's Address: ____________________
Street/PO Box City State Zip

Responsible Party

Name of person responsible for this account: ____________________

Relation: ____________________ Work Phone #: (_____)__________ Home Phone #: (_____)__________

Address: ____________________
Street City State Zip

Spouse Information

His / Her Name: ____________________ Birthdate: ___/___/___ Social Security #: ____________________

Employer: ____________________ Work Phone #: (_____)__________ Ext: ______

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________ Insured's Social Security #: ____________________ Insured's Birthdate: ___/___/___ Relation: __________

Insured's Employer: ____________________ Employer's Address: ____________________
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: ____________________ Phone #: (_____)__________ Group # (Plan, Local or Policy #): ____________________

Insured's Name: ____________________ Insured's Social Security #: ____________________ Insured's Birthdate: ___/___/___ Relation: __________

Insured's Employer: ____________________ Employer's Address: ____________________
Street/PO Box City State Zip

Form 008680 R/07/08 Item 8101

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? ______________________________

Previous / Present Dentist: ____________ Last Visit Date: ________
(Please Circle)

Have you ever had periodontal treatment? ❑ Yes ❑ No
If yes, when? ____________

Do you clench or grind your teeth? ❑ Yes ❑ No

Do you have any pain, popping, or clicking from your jaw? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Do you floss daily? ❑ Yes ❑ No Brush Daily? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ____________

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ____________

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________

Phone #: (______)____________ Date of last visit: ____________

Your current physical health is: ❑ 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 ever taken Phen-Fen, Redux or Pondimin? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: ________ Are you nursing? ❑ Yes ❑ No

Indicate any of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Y N Abnormal Bleeding
Y N Anemia
Y N Arthritis
Y N Artificial Joints/Replacement
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Type: ________
Date: ________
Y N Chemotherapy

Y N Congenital Heart Defect
Y N Diabetes
Y N Eating Disorder
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Attack
Date: ________
Y N Heart Disease

Y N Heart Murmur
Y N Heart Surgery
Date: ________
Y N Hemophilia
Y N Hepatitis (circle one) A B C
Y N Herpes
Y N High Blood Pressure
Y N HIV+/ AIDS / ARC
Y N Kidney Diseases
Y N Liver Disease/Jaundice
Y N Low Blood Pressure

Y N Mitral Valve Prolapse
Y N Neurological Disorder
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease

Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Substance Abuse
Y N Thyroid Problems
Y N Transplant
Date: ________
Y N Tuberculosis (TB)
Y N Tumors
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: ____________

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: ____________

Are you allergic to any of the following? Circle "Yes" or "No" to each item.

Y N Aspirin
Y N Amoxicillin
Y N Codeine

Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals

Y N Latex
Y N Penicillin

Y N Sedatives
Y N Sulfa Drugs

Y N Tetracycline
Y N Other

Please list anything additional that causes allergic reactions: ____________

History Review

Dentist Signature ______________________________ Date ____________

Authorization & Release

I certify that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform the office of any changes in my medical status. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize Dr. Rogers to perform all recommended treatment mutually agreed upon. I authorize the release of any information, including the diagnosis and the records of any treatment rendered to me or my child, to third party payors and/or health practitioners. I authorize and request my insurance company to pay, directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance may not cover all the costs of treatment. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event any payments are not received by agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account.

Signature of Patient or Parent/Guardian if a Minor ____________ Date ____________ Please Print Name of Patient or Parent/Guardian ____________ Relationship to Patient ____________