BRIANA CHAVEZ, DDS, INC.
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PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If the appointment is for you, start here:

DATE:			
NAME:			
SPOUSE:			
ADDRESS:			
CITY:	STATE:	ZIP:	
PHONE:	ALTERNATE:		
EMAIL:			
BIRTHDATE:	AGE:	MALE:	FEMALE:
MARRIED:	SINGLE:	DIVORCED:	WIDOWED:
SOCIAL SECURITY NUMBER:			

If the appointment is for your child, start here:

DATE:			
NAME:			
ADDRESS:			
CITY:	STATE:	ZIP:	
PHONE:	ALTERNATE:		
EMAIL:			
BIRTHDATE:	AGE:	MALE:	FEMALE:
SCHOOL:	GRADE:		
SOCIAL SECURITY NUMBER:			

Dental Insurance: Primary Carrier

INSURANCE COMPANY:	
GROUP NO.:	
EMPLOYEE:	
BIRTHDATE:	DATE EMPLOYED:
UNION OR LOCAL NO.:	
EMPLOYEE NO.:	
SOCIAL SECURITY NUMBER:	

Dental Insurance: Secondary Carrier

INSURANCE COMPANY:	
GROUP NO.:	
EMPLOYEE:	
BIRTHDATE:	DATE EMPLOYED:
UNION OR LOCAL NO.:	
EMPLOYEE NO.:	
SOCIAL SECURITY NUMBER:	

Getting to know you

Is another member of your family or relative a patient at our office?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY:		
YOUR PREVIOUS ADDRESS:		
CITY:	STATE:	ZIP:
PERSON TO CONTACT IN AN EMERGENCY:		
PHONE:	ALTERNATE:	
ADDRESS:		
CITY:	STATE:	ZIP:
Closest relative not living with you		
PHONE:	ALTERNATE:	
ADDRESS:		
CITY:	STATE:	ZIP:

1. Are you having pain or discomfort at this time? .... Yes | No
2. Have you been a patient in the hospital during the past two years? .... Yes | No
3. Have you been under the care of a medical doctor during the past two years? .... Yes | No

Physician's Name: Phone:

Address:

4. Have you taken any medication or drugs during the past two years? .... Yes | No
5. Are you taking any medication, drug or pills? .... Yes | No

If yes, please list:

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .... Yes | No

If yes, please list:

7. Indicate which of the following you have had or have at present.

Condition			Condition			Condition		
Heart Failure	Yes	No	Artificial Joint (hip, knee, etc)	Yes	No	Hepatitis B (Serum)	Yes	No
Heart Disease / Attack	Yes	No	Kidney Trouble	Yes	No	Venereal Disease	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	A.I.D.S.	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Cold Sores / Fever Blister	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Arteriosclerosis	Yes	No	Cosmetic Surgery	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Anemia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine	Yes	No	Radiation Therapy	Yes	No	Nervousness	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Psychiatric Treatment	Yes	No
Stroke	Yes	No	Hepatitis A (Infectious)	Yes	No	Developmentally Disabled	Yes	No

8. When you walk up stair or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .... Yes | No
9. Do your ankles swell during the day? .... Yes | No
10. Do you use more than two pillows to sleep? .... Yes | No
11. Have you lost or gained more than 10 pounds in the past year? .... Yes | No
12. Do you ever wake up from sleep and feel short of breath? .... Yes | No
13. Are you on a special diet? .... Yes | No
14. Have your medical doctors ever said you have cancer or a tumor? .... Yes | No
15. Do you or have you ever had any disease, condition, or problem not listed? .... Yes | No

If yes, please list:

For women only:

Are you pregnant? Yes | What month? | No   Are you nursing? Yes | No   Birth Control Pills? Yes | No

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 knowledge.

Patient Signature____Date______________

CONSENT:

1. The undersigned hereby authorized doctor to take x-ray, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. 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.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18% APR) may be added to my account.

Patient____Date__________________Witness_________________________

Parent or Responsible Party____Relationship to Patient__________________________________