BRIANA CHAVEZ, DDS, INC.
GENERAL | FAMILY | RESTORATIVE | AESTHETIC
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PATIENT REGISTRATION

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:	SEX ASSIGNED AT BIRTH *(**please circle one**)* :	**MALE**	**FEMALE** **INTERSEX/OTHER**
MARITAL STATUS (**please circle one**):	**SINGLE**	**MARRIED**	**DIVORCED**	**WIDOWED**
SOCIAL SECURITY #:				

If the appointment is for your child, start here:				
DATE:				
NAME:				
ADDRESS:				
CITY:		STATE:		ZIP:
PHONE:		ALTERNATE:		
EMAIL:				
BIRTHDATE:	AGE:	SEX ASSIGNED AT BIRTH *(**please circle one**)* :	**MALE**	**FEMALE** **INTERSEX/OTHER**
SCHOOL:		GRADE:		
SOCIAL SECURITY #:				

Dental Insurance: Primary Carrier		
INSURANCE COMPANY:		
GROUP #:		
EMPLOYEE:	DATE EMPLOYED:	EMPLOYEE #:
BIRTHDATE:		
UNION OR LOCAL #:		
SOCIAL SECURITY #:		

Dental Insurance: Secondary Carrier		
INSURANCE COMPANY:		
GROUP #:		
EMPLOYEE:	DATE EMPLOYED:	EMPLOYEE #:
BIRTHDATE:		
UNION OR LOCAL #:		
SOCIAL SECURITY #:		

Getting to know you			
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? *(**please circle one**)*		**YES**	**NO**
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:	

PATIENT HEALTH HISTORY

1. Are you having pain or discomfort at this time? ..... Yes No
2. Are you under a physician's care now? ..... Yes No

Physician's Name: _____ **Physician's Phone:** _____

Physician's Address/Location: _____

3. Have you ever been hospitalized or had a major operation? ..... Yes No

If yes, please explain: _____

4. Have you ever had a serious head or neck injury? ..... Yes No

If yes, please explain: _____

5. Are you currently taking any medications, pills, or drugs? ..... Yes No

If yes, please list: _____

6. Do you take, or have you taken, Phen-Fen or Redux? ..... Yes No

If yes, please explain: _____

7. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ..... Yes No

If yes, please explain: _____

8. Are you on a special diet? ..... Yes No

If yes, please explain: _____

9. Do you use tabacco? ..... Yes No
10. Do you use controlled substances? ..... Yes No

If yes, please explain: _____

11. Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Acrylic	Yes No
Metal	Yes No	Codeine	Yes No	Local Anesthetics	Yes No
Latex	Yes No	Sulfa Drugs	Yes No		

If others, please list: _____

12. Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Excessive Bleeding	Yes No	Lung Disease	Yes No
Alzheimer's Disease	Yes No	Excessive Thirst	Yes No	Mitral Valve Prolapse	Yes No
Anaphylaxis	Yes No	Fainting Spells/Dizziness	Yes No	Osteoporosis	Yes No
Anemia	Yes No	Frequent Cough	Yes No	Pain in Jaw Joints	Yes No
Angina	Yes No	Frequent Diarrhea	Yes No	Parathyroid Disease	Yes No
Arthritus/Gout	Yes No	Frequent Headaches	Yes No	Psychiatric Care	Yes No
Artificial Heart Valve	Yes No	Genital Herpes	Yes No	Radiation Treatments	Yes No
Artificial Joint (hip,knee,etc.)	Yes No	Glaucoma	Yes No	Recent Weight Loss	Yes No
Asthma	Yes No	Hay Fever	Yes No	Renal Dialysis	Yes No
Blood Disease	Yes No	Heart Attack/Failure	Yes No	Rheumatic Fever	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Rheumatism	Yes No
Breathing Problems	Yes No	Heart Pacemaker	Yes No	Scarlet Fever	Yes No
Bruise Easily	Yes No	Heart Trouble/Disease	Yes No	Shingles	Yes No
Cancer	Yes No	Hemophilia	Yes No	Sickle Cell Disease	Yes No
Chemotherapy	Yes No	Hepatitis A	Yes No	Sinus Trouble	Yes No
Chest Pains	Yes No	Hepatitis B or C	Yes No	Spina Bifida	Yes No
Cold Sores/Fever Blisters	Yes No	Herpes	Yes No	Stomach/Intestinal Disease	Yes No
Congenital Heart Disorder	Yes No	High Blook Pressure	Yes No	Stroke	Yes No
Convulsions	Yes No	High Cholesterol	Yes No	Swelling of Limbs	Yes No
Cortisone Medicine	Yes No	Hives or Rash	Yes No	Thyroid Disease	Yes No
Cosmetic Surgery	Yes No	Hypoglycemia	Yes No	Tonsillitis	Yes No
Diabetes	Yes No	Irregular Heartbeat	Yes No	Tuberculosis	Yes No
Drug Addiction	Yes No	Kidney Problems	Yes No	Tumors or Growths	Yes No
Easily Winded	Yes No	Leukemia	Yes No	Ulcers	Yes No
Emphysema	Yes No	Liver Disease	Yes No	Venereal Disease	Yes No
Epilepsy or Seizures	Yes No	Low Blood Pressure	Yes No	Yellow Jaundice	Yes No

13. Do you or have you ever had any disease, condition, or problem not listed above? ..... Yes No

If yes, please list: _____

(FOR WOMEN ONLY)

Are you pregnant/trying? Yes No Are you nursing? Yes No Taking oral contraceptives? Yes No

If yes, due date: _____

*** 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.**

***** ***CONSENT:***

1. The undersigned hereby authorizes doctor to take x-rays, study models, photos, 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 by **Briana Chavez, DDS, Inc**. 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 1.5% finance charge (18% APR) may be added to my account.

*** Patient Signature:** _____ **Date:** _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____