SANTA CLARA ENDODONTICS

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This information is necessary for your health and our records, and will be considered confidential.

PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____ (Circle One) Mr. Dr. Mrs. Ms. Miss ____/____/____ Birthdate

Nickname _____ Social Security # ____-____-_____

Home Phone ( )_____ Business Phone ( )_____ Cellphone ( )_____

Mailing Address _____ City _____ Zip _____

Street Address or Location _____ How Long? _____

Previous Address (if less than 3 years at current address) _____

Occupation _____ Patient's Employer _____

Employer's Address _____ City _____ Zip _____

Driver's License # _____ E-mail Address _____

Nearest relative not living with you _____ Relationship _____ Phone ( ) _____

In case or emergency, call _____ Relationship _____ Phone ( ) _____

Has any member of your family ever been treated in our office? (Circle One) Yes No

FINANCIAL INFORMATION

Person financially responsible (if self, proceed to next section) _____ Relationship _____

Social Security # ____ -____-____ Driver's License # _____ Home Phone ( ) _____

Mailing Address _____ City _____ Zip _____

Occupation _____ Employer _____ Business Phone ( ) _____

Employer's Address _____ How long with current employer? _____

FAMILY INFORMATION

Name of spouse or parent (circle one if applicable) _____

Occupation _____ Employer _____ Business Phone ( ) _____

INSURANCE INFORMATION

Are you covered by dental insurance? ❑ Yes ❑ No If yes, please complete this section.

PRIMARY INSURANCE

Insured's Name _____

SS # _____ -_____ -_____ Birthdate _____ /_____ /_____

Employer _____

Ins. Co. or Plan _____

Group/Union Name _____

Group or Policy # _____ Local # _____

Date Employed _____

How much is the deductible? _____

SECONDARY INSURANCE ❑ Yes ❑ No

Insured's Name _____

SS # _____ -_____- ____ Birthdate _____/ _____/_____

Employer _____

Ins. Co. or Plan _____

Group/Union Name _____

Group or Policy # _____ Local # _____

Date Employed _____

How much, if any, has been satisfied? _____

Has the patient had any dental care under this plan this year? ❑ Yes ❑ No

PLEASE COMPLETE OTHER SIDE

HEALTH HISTORY

Patient Name _____ **Birth Date:** _____

Mark appropriate answer

1. ❑ Yes ❑ No Is your general health good?
2. ❑ Yes ❑ No Has there been a change in your health in the last year?
3. ❑ Yes ❑ No Have you been hospitalized or had a serious illness in the last three years
   Why? _____
4. ❑ Yes ❑ No Are you being treated by a physician now? For what?
   Date of last medical exam: _____ Date of last Dental Appt: _____
5. ❑ Yes ❑ No Have you had problems with prior dental treatment?
6. ❑ Yes ❑ No Are you in pain now?

HAVE YOU EXPERIENCED:

7. ❑ Yes ❑ No Chest pain (angina)?
8. ❑ Yes ❑ No Shortness of breath?
9. ❑ Yes ❑ No Recent weight loss, fever, nightsweats?
10. ❑ Yes ❑ No Persistent cough, coughing up blood?
11. ❑ Yes ❑ No Bleeding problems, bruising easily?
12. ❑ Yes ❑ No Sinus problems?
13. ❑ Yes ❑ No Difficulty swallowing?
14. ❑ Yes ❑ No Dizziness?
15. ❑ Yes ❑ No Ringing in the ears?
16. ❑ Yes ❑ No Headaches?
17. ❑ Yes ❑ No Fainting spells?
18. ❑ Yes ❑ No Blurred vision?
19. ❑ Yes ❑ No Seizures?
20. ❑ Yes ❑ No Jaundice?

DO YOU HAVE OR HAVE YOU HAD:

21. ❑ Yes ❑ No Heart disease?
22. ❑ Yes ❑ No Heart attack, heart defects?
23. ❑ Yes ❑ No Heart murmurs?
24. ❑ Yes ❑ No Rheumatic fever?
25. ❑ Yes ❑ No Stroke, hardening of arteries?
26. ❑ Yes ❑ No High blood pressure?
27. ❑ Yes ❑ No TB, emphysema, other lung disease?
28. ❑ Yes ❑ No Hepatitis, other liver disease?
29. ❑ Yes ❑ No Stomach problems, ulcers?
30. ❑ Yes ❑ No Allergies to: drugs, foods, medications, latex?
31. ❑ Yes ❑ No HIV / AIDS?
32. ❑ Yes ❑ No Tumors, cancer?
33. ❑ Yes ❑ No Arthritis, rheumatism?
34. ❑ Yes ❑ No Eye disease?
35. ❑ Yes ❑ No Skin disease?
36. ❑ Yes ❑ No VD (Syphilis or gonorrhea)
37. ❑ Yes ❑ No Herpes?
38. ❑ Yes ❑ No Kidney, bladder disease?
39. ❑ Yes ❑ No Thyroid, adrenal disease?
40. ❑ Yes ❑ No Diabetes?
41. ❑ Yes ❑ No Autoimmune Disease?

DO YOU HAVE OR HAVE YOU HAD:

41. ❑ Yes ❑ No Psychiatric care?
42. ❑ Yes ❑ No Radiation treatments?
43. ❑ Yes ❑ No Chemotherapy?
44. ❑ Yes ❑ No Prosthetic heart valve?
45. ❑ Yes ❑ No Artificial Joint?
46. ❑ Yes ❑ No Hospitalization?
47. ❑ Yes ❑ No Blood transfusions?
48. ❑ Yes ❑ No Surgeries?
49. ❑ Yes ❑ No Pacemaker?

ARE YOU TAKING OR HAVE YOU TAKEN:

50. ❑ Yes ❑ No Recreational drugs?
51. ❑ Yes ❑ No Tobacco in any form?
52. ❑ Yes ❑ No Alcohol in excess?
53. ❑ Yes ❑ No Drugs, medicines, (incl. Aspirin)
    Please List: _____
54. ❑ Yes ❑ No Phen-fen or Redux?
55. ❑ Yes ❑ No Bisphophonates?
56. ❑ Yes ❑ No Monoclonal Antibody drugs?

WOMEN ONLY:

55. ❑ Yes ❑ No Are you or could you be pregnant?
56. ❑ Yes ❑ No Taking birth control pills?

ALL PATIENTS:

57. ❑ Yes ❑ No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____

Please list any allergies to medications: _____

AUTHORIZATION *(Please Read Carefully)*

The above information is accurate and complete to the best of my knowledge. I understand that it is my responsibility to inform my doctor If there are any changes in my health. I authorize James Jespersen D.D.S., Inc. to use my healthcare information and may disclose such information to my Insurance company (ies) and their agents for the purpose of obtaining payment for services.

Signature: _____ Date Signed: ____ / ____ / ____ Relationship to patient: _____

For Office use ONLY: BP: ____ / ____ P: _____ Doctor's Initial: _____ Date: _____

Update Information	Changes in Health History	Patient Signature	Dr.'s Signature
____ / ____ / ____	❑ **No changes since my last visit** ❑ **Yes: Please see changes in RED ink**	✗	✗

Date: _____ Referred by: _____

Phone: ( ) _____ City: _____