Bella Terra Dental
1110W Kettleman Ln #47, Lodi, CA 95240

DATE: _____

GENERAL HEALTH INFORMATION

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ☐ Cleaning ☐ Toothache ☐ Other _____
2. Are there other conditions of which we should be aware? YES ◯ NO ◯ If yes, please specify: _____
3. When did you last visit a dentist? _____
4. What treatment was performed? _____
5. Was the treatment completed? _____
6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES ◯ NO ◯
8. Have you had gum (periodontal) treatment? YES ◯ NO ◯
9. Have you ever had prolonged bleeding after an extraction? YES ◯ NO ◯ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ◯ NO ◯ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ◯ NO ◯ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ◯ NO ◯ If yes, please specify: _____
13. Do your gums bleed easily? YES ◯ NO ◯
14. Do you feel you have bad breath? YES ◯ NO ◯
15. Are your teeth sensitive to hot or cold? YES ◯ NO ◯
16. Would you like your teeth whiter? YES ◯ NO ◯
17. Are you happy with your smile? YES ◯ NO ◯ If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ◯ NO ◯ If yes, please specify: _____ Dr. Name: _____
   Dr. Phone: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ◯ NO ◯ If yes, please specify: _____
4. (Women) Are you pregnant now? YES ◯ NO ◯ If yes, how many months? _____ Are you nursing? YES ◯ NO ◯
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL HEART VALVE	YES ◯	NO ◯		HEPATITIS	YES ◯	NO ◯	
AIDS/HIV+	YES ◯	NO ◯		HIGH BL. PRESSURE	YES ◯	NO ◯	
ANEMIA	YES ◯	NO ◯		JAUNDICE	YES ◯	NO ◯	
ANGINA	YES ◯	NO ◯		JOINT REPLACEMENT	YES ◯	NO ◯	
ARTHRITIS	YES ◯	NO ◯		KIDNEY DISEASE	YES ◯	NO ◯	
ASTHMA	YES ◯	NO ◯		LATEX ALLERGY	YES ◯	NO ◯	
BISPHOSPHONATE THERAPY	YES ◯	NO ◯		LIVER PROBLEMS	YES ◯	NO ◯	
BLEEDING PROBLEMS	YES ◯	NO ◯		LOW BL. PRESSURE	YES ◯	NO ◯	
CANCER	YES ◯	NO ◯		LUNG DISEASE	YES ◯	NO ◯	
CHEMO/RAD THERAPY	YES ◯	NO ◯		PACEMAKER	YES ◯	NO ◯	
COSMETIC SURGERY	YES ◯	NO ◯		PSYCHIATRIC CARE	YES ◯	NO ◯	
DIABETES	YES ◯	NO ◯		RHEUMATIC FEVER	YES ◯	NO ◯	
DIZZY SPELLS	YES ◯	NO ◯		SINUS TROUBLE	YES ◯	NO ◯	
DRUG ADDICTION	YES ◯	NO ◯		SLEEP APNEA	YES ◯	NO ◯	
EMPHYSEMA	YES ◯	NO ◯		TOBACCO	YES ◯	NO ◯	
EPILEPSY	YES ◯	NO ◯		STROKE	YES ◯	NO ◯	
FAINTING	YES ◯	NO ◯		THYROID PROBLEMS	YES ◯	NO ◯	
GLAUCOMA	YES ◯	NO ◯		TMD OR TMJ	YES ◯	NO ◯	
HEART ATTACK/SURGERY	YES ◯	NO ◯		TUBERCULOSIS	YES ◯	NO ◯	
HEART MURMUR/PROBLEMS	YES ◯	NO ◯		VENEREAL DISEASE	YES ◯	NO ◯	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____

(Parent if patient is a Minor)

Doctor's Signature _____ Date _____

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PATIENT INFORMATION

PATIENT

Name _____
Last First

Address _____ Apt. # _____

City _____ Zip _____
How long at this address? _____
Phone ( ) _____
Cell/Pager ( ) _____
E-mail _____
Social Security # _____
DL# _____
Age _____ Birthdate _____
Primary Language _____
Ethnicity _____

GETTING TO KNOW YOU

Do you have family members who may need dental care?
If so, please list name & relationship (son, daughter, husband)

1: _____ 2: _____

How did you hear about our office? (Circle one)

- **Family-Friend**
- **Flyer-Coupon**
- **Office Sign**
- **Office Transfer**
- **Insurance Plan**
- **Direct Mail Postcard**
- **Internet-Website**

I want information in Spanish: YES _____ NO _____

EMPLOYMENT

Occupation _____
Employer _____
How Long? _____
Business Address _____
City _____ Zip _____
Business Phone ( ) _____ Ext. # _____
Verified By _____ Date _____
(Office use only)

REFERENCES

Name _____
Last First
Phone ( ) _____
Name _____
Phone ( ) _____
Spouse's Name _____
Last First
Spouse's Work Phone ( ) _____

PERSON TO CONTACT FOR EMERGENCY:

_____
Last First
Phone ( ) _____

Physician _____ Phone ( ) _____

RESPONSIBLE PARTY (If same as above, please skip)

Name _____
Last First
Address _____ Apt. # _____
City _____ Zip _____
How long at this address? _____
Phone ( ) _____
Social Security # _____ DL# _____
Relationship to Patient _____
Age _____ Birthdate _____

INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____
Address _____
City, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Circle one)

Plan Name _____
Address _____
City, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE / MEDICAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name _____
Address _____
City, State, Zip _____
Insurance / Plan Phone # _____
Employer _____
Union/Local _____ Group # _____ Plan# _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

_____
Signature of Responsible Party or Patient (Parent if Patient is a Minor) Date

(COMPLETE BOTH SIDES)