FREMONT DENTAL EXCELLENCE
1895 Mowry Ave Suite#120
Fremont, California 94538
(510)494-8181
www.fremontdentalx.com

1 PATIENT INFORMATION

Date_____
SS#_____
Patient Name_____
Address_____
City_____ State_____ Zip Code_____
E-mail_____
Sex M__ F__ Age_____
Birth date_____

Married __ Widowed __ Single __ Minor __
Separated __ Divorced __ Partnered for __ years

Patient Employer/School_____
Occupation_____
Employer/School Address_____
_____
Employer/School Phone (___) _____

Spouse's Name_____
Birth date_____
SS#_____
Spouse's Employer_____
Occupation _____
Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account?_____
Relationship to patient_____
Insurance Co._____
Group #_____
Is the patient covered by additional insurance?_____
Subscriber's Name_____
Birthdate_____ SS#_____
Relationship to patient_____
Insurance Co._____
Group #_____

ASSIGNAMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Co.)
And assign directly to Dr. Gustavo Lemus all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date **Relationship to Patient**

3 PHONE NUMBERS

Home (___)_____ Work (___) _____ Ext_____ Cell Phone (___) _____
Spouse's Work (___) _____ Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household).
Name_____ Relationship_____
Home Phone(___) _____ Work Phone (___) _____

4 DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	yes__ no___	Cigarette, pipe, or cigar smoking	yes__ no___
Bleeding gums	yes__ no___	Clicking or popping jaw	yes__ no___
Blisters on lips or mouth	yes__ no___	Dry mouth	yes__ no___
Burning sensation on tongue	yes__ no___	Fingernail biting	yes__ no___
Chew on one side of mouth	yes__ no___	Food collection between the teeth	yes__ no___
		Foreign objects	yes__ no___
		Grinding teeth	yes__ no___
		Gums swollen or tender	yes__ no___
		Jaw pain or tiredness	yes__ no___
		Lip or cheek biting	yes__ no___
		Loose teeth or broken fillings	yes__ no___
		Mouth breathing	yes__ no___
		Mouth pain, brushing	yes__ no___
		Orthodontic Treatment	yes__ no___
		Pain around ear	yes__ no___
		Periodontal Treatment	yes__ no___
		Sensitivity to cold	yes__ no___
		Sensitivity to heat	yes__ no___
		Sensitivity to sweets	yes__ no___
		Sensitivity when biting	yes__ no___
		Sores or growths in your mouth	yes___ no___

How often do you floss?_____

How often do you brush?_____

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5 HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "**fen-phen**"? These include combinations of **Ionimin, Adipex, Fastin** (brand names of **phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)**. Yes____ No_____

Bisphosphonate Medication (Fosomax, Actonel, Boniva, Aredia, Bonefos, Didronel, Zometa). Yes____ No_____

Please mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	yes___ no___	Epilepsy	yes___ no___	Respiratory Disease	yes___ no___
Anemia	yes___ no___	Fainting or dizziness	yes___ no___	Rheumatic Fever	yes___ no___
Arthritis, Rheumatism	yes___ no___	Glaucoma	yes___ no___	Scarlet Fever	yes___ no___
Artificial Heart Valves	yes___ no___	Headaches	yes___ no___	Shortness of breath	yes___ no___
Artificial Joints	yes___ no___	Heart Murmur	yes___ no___	Sinus Trouble	yes___ no___
Asthma	yes___ no___	Heart problems	yes___ no___	Skin rash	yes___ no___
Back problems	yes___ no___	Hepatitis Type_____	yes___ no___	Special Diet	yes___ no___
Bleeding abnormally, with extractions or surgery	yes___ no___	Herpes	yes___ no___	Stroke	yes___ no___
		High Blood Pressure	yes___ no___	Swollen feet or ankles	yes___ no___
Blood Disease	yes___ no___	Jaundice	yes___ no___	Swollen neck or gland	yes___ no___
Cancer	yes___ no___	Jaw Pain	yes___ no___	Thyroid problems	yes___ no___
Chemical dependency	yes___ no___	Kidney Disease	yes___ no___	Tonsillitis	yes___ no___
Chemotherapy	yes___ no___	Liver Disease	yes___ no___	Tuberculosis	yes___ no___
Circulatory problem	yes___ no___	Low Blood Pressure	yes___ no___	Tumor or growth on the head or neck	yes___ no___
Congenital Heart Lesions	yes___ no___	Mitral Valve Prolapse	yes___ no___		
Cortisone Treatments	yes___ no___	Nervous problems	yes___ no___	Ulcer	yes___ no___
Cough, persistent or bloody	yes___ no___	Pacemaker	yes___ no___	Venereal Disease	yes___ no___
Diabetes	yes___ no___	Psychiatric treatment	yes___ no___	Weight Loss, unexplained	yes___ no___
Emphysema	yes___ no___	Radiation treatment	yes___ no___		

Do you wear contact lenses? yes___ no___

Women:

Are you pregnant? yes___ no___ Due date_____ Are you nursing? yes___ no___

Taking birth control pills? yes___ no___

MEDICATIONS	ALLERGIES	
List any medications you are currently taking and the correlating diagnosis:	__ Aspirin	__Local Anesthetic
_____	__ Barbiturates (sleeping pills)	__Penicillin
_____	__Codeine	__Sulfa
Pharmacy Name_____	__Iodine	__Other_____
Phone (____) _____	__Latex	_____

Patient's Signature_____ Date _____

Doctor's Signature_____ Date_____