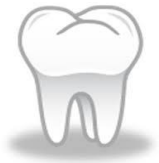

Welcome to Cali Care Dental

Thank you for selecting us. To help us meet all your health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____.
SSN _____ Date of Birth _____.
Address _____ City _____.
State _____ Zip _____ Email _____.
Home Phone _____ Cell Phone _____.
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Partner
Spouse or Parent/Guardian's Name _____.
Emergency Contact _____ Phone _____.
Primary Physician _____ Phone _____.
Whom may we thank for referring you? _____.

Responsible Party

Name _____ Date of Birth _____.
Relationship to Patient _____ Address _____.
Cell Phone _____ Email _____.
SSN _____ Employer _____.
Work Phone _____.

Insurance Information

Name of Insured _____ Date of Birth _____.
Relationship to Patient _____ SSN _____.
Name of Employer _____ Work Phone _____.
Insurance Company _____ Group # _____.
Policy/ID# _____.
Insurance Phone _____.

Regarding finances and treatment plans is there anyone you would like us to contact? Yes ☐ No ☐ If yes please let us know who we may contact.
Name: _____ Phone: _____.

Patient Medical/Dental History

Please individually mark Yes or No Do you have or have had any of the following?

Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Emphysema
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Implants	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Jaundice
☐	☐	HIV/AIDS	☐	☐	Sexually Transmitted Disease
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure
☐	☐	Heart Disease	☐	☐	Heart Attack
☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse
☐	☐	Pacemaker	☐	☐	Angina
☐	☐	Chemotherapy	☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Diabetes	☐	☐	Epilepsy/Seizures
☐	☐	Fainting Spells	☐	☐	Thyroid Problems
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Phen-Fen/Redux	☐	☐	Parkinson Disease
☐	☐	Glaucoma	☐	☐	Hay Fever/Allergies
☐	☐	Stroke	☐	☐	Tuberculosis
☐	☐	Sleep Apnea	☐	☐	Acid Reflux/GERD
☐	☐	Premedicate	☐	☐	Recent Weight Loss
☐	☐	Stents	☐	☐	High/Low Cholesterol

Other_____.

Please individually mark Yes or No are you allergic to the following?

Yes	No		Yes	No	
☐	☐	Local Anesthetics (e.g Novocain)	☐	☐	Penicillin
☐	☐	Clindamycin	☐	☐	Sulfa Drugs
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Sedatives	☐	☐	Latex
☐	☐	Metals (e.g nickel, mercury, ect)			

Other_____.

Women Only:	Yes	No
Are you pregnant/think you might be pregnant	☐	☐
Are you taking birth control	☐	☐

Name of Previous Dentist and Location_____.

_____Date of Last Exam_____.

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold food/liquids?	☐	☐

	Yes	No
Do you feel pain to any of your teeth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you have TMJ?	☐	☐
Do you bite you lips or cheeks frequently?	☐	☐
Do you get frequent headaches?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you like your smile?	☐	☐

Patient Signature:_____Date_____.
Doctor Signature:_____Date_____.
Patient Signature:_____Date_____.
Doctor Signature:_____Date_____.
Patient Signature:_____Date_____.
Doctor Signature:_____Date_____.
Patient Signature:_____Date_____.
Doctor Signature:_____Date_____.

List of Medications:_____.
_____.
_____.
_____.
_____.
_____.
_____.
_____.
_____.
_____.
_____.
_____.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize _____/or staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to _____ insurance benefits otherwise payable to be. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_____Date_____.