ACADEMY DENTAL
781 Academy Dr
Solana Beach, CA 92075

Patient Information Form

Patient Information

Name _____ Nickname _____

Birthday _____

Home Address _____ City _____ Zip Code _____

Email _____ Cell _____ Home _____

Primary Physician _____ Phone number _____
Pharmacy _____ Phone number _____
Current/Previous Dentist _____ Phone number _____
Emergency Contact _____ Phone Number _____
Reason for Visit _____

Dental Insurance

Provider _____ Group Number _____
Employer _____

Insured Subscriber ID Number or Social Security Number _____

Name of Primary Person Insured (ie. You, Husband, Wife, etc) _____

Insured Date of Birth _____

I give permission to Academy Dental to submit insurance claims and receive payment on my behalf: Signature _____

Medical History

List of Hospitalization or Surgeries

Date _____ Reason _____
Date _____ Reason _____

List of Medications

_____

_____

_____

Current or History of the following:

	Yes	No
Blood Thinners (Pavix, Warfarin, Coumadin)	☐	☐
Phen-Fen	☐	☐
Bisphosphonates (Fosamax, Boniva, Actonel)	☐	☐

Females

	Yes	No
Pregnant	☐	☐
Nursing	☐	☐
Oral Contraception	☐	☐

Medical Conditions

Cardiovascular

	Yes	No
Heart Attack	☐	☐
Chest Pain	☐	☐
Heart Murmur	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐

Other _____

Liver/ Kidney

	Yes	No
Hepatitis	☐	☐
Liver Disease	☐	☐
Dialysis	☐	☐
Kidney Disease	☐	☐

Diabetes

	Yes	No
Type 1	☐	☐
Type 2	☐	☐

Blood Disorders

	Yes	No
HIV/ AIDS	☐	☐
Anemia	☐	☐
Bleeding Disorders	☐	☐
Leukemia	☐	☐

Other _____

Psychiatric

	Yes	No
Depression	☐	☐
Schizophrenia	☐	☐

Other _____

Cancer

	Yes	No
Chemotherapy	☐	☐
Radiation	☐	☐

Other _____

Steroid/ Auto Immune

	Yes	No
Steroid Supplement	☐	☐
Lupus	☐	☐

Miscellaneous

	Yes	No
Joint Replacement	☐	☐
Tuberculosis	☐	☐
COPD	☐	☐
Glaucoma	☐	☐
Epilepsy/ Seizures	☐	☐
Herpes/ STDs	☐	☐
Hyperthyroid	☐	☐
Hypothyroid	☐	☐
Osteoporosis	☐	☐
Head/ Neck Trauma	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐

Allergies

	Yes	No
Aspirin	☐	☐
Clindamycin	☐	☐
Codeine	☐	☐
Doxycycline	☐	☐
Narcotics	☐	☐

	Yes	No
Sulfa Drug	☐	☐
Vicodin	☐	☐
Erythromycin	☐	☐
Dental Anesthesia	☐	☐
Iodine	☐	☐

	Yes	No
Latex	☐	☐
Motrin	☐	☐
Penicillin	☐	☐
Narcotics	☐	☐

Other _____

I certify that I have read and understand the above questions. The above questions have been answered to the best of my abilities. I understand that incorrect or incomplete information can lead to serious health complications during treatment. Dr. Belderes and staff are not responsible for any information that was omitted from this form. I have been notified of the California Dental Fact Sheet at http://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf

Patient Signature _____ Date _____

Parent/ Guardian _____ Date _____