



Julio E. Hernandez DMD
 Rita Dargham DMD
 FAMILY & COSMETIC DENTISTRY

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms
 Preferred Name: _____
 Mailing Address: Street _____ City, State _____ Zip _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Birthday: _____ Male Female Single Married Widowed Divorce
 Social Security Number: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Whom can we thank for referring you to us? _____

Additional Information

Are you under a physician's care now? Yes No
 Physician's name: _____ Specialty: _____
 Physician's address: _____ Phone number: _____

In Case of Emergency Contact

Name: _____ Relationship: _____
 Home phone: _____ Work phone: _____ Cell phone: _____

Person responsible for this account: Same as Above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms
 Mailing Address: (Street, City, State, Zip) _____
 Home Phone: _____ Cell Phone: _____ Email: _____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits other payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: X _____ Date: _____



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Please answer the following questions as accurately as possible. Thank you! (Please circle Yes or No)

- | | | | |
|--|-----|----|-------------------------------|
| Have you ever been hospitalized or had major operation | Yes | No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | Yes | No | If yes, please explain: _____ |
| Do you get headaches? | Yes | No | If yes, please explain: _____ |
| Do you clench or grind your teeth? | Yes | No | If yes, please explain: _____ |
| Do you snore? | Yes | No | If yes, please explain: _____ |
| Do you wake up tired in the morning? | Yes | No | If yes, please explain: _____ |
| Do you have difficulty breathing through your nose? | Yes | No | If yes, please explain: _____ |
| Are you on a special diet? | Yes | No | If yes, please explain: _____ |
| Do you use tobacco? | Yes | No | If yes, please explain: _____ |
| Have you ever had any orthodontic treatment? | Yes | No | If yes, please explain: _____ |
| Are you interested in straightening your teeth? | Yes | No | If yes, please explain: _____ |

Please list any medications, pills, or drugs you are taking: _____

Women: Are you pregnant or trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

- | | | | | |
|--|---|--|--|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Dialysis | Other Serious Illness
Please Explain: _____ |
| <input type="radio"/> Alzheimer's | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A, B, or | <input type="radio"/> Rheumatic Fever | |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Headaches | <input type="radio"/> Rheumatism | _____ |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Scarlet Fever | _____ |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood | <input type="radio"/> Shingles | _____ |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hives or Rash | <input type="radio"/> Sickle Cell | _____ |
| <input type="radio"/> Artificial Heart | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hypoglycemia | <input type="radio"/> Sinus Trouble | _____ |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Irregular | <input type="radio"/> Spina Bifida | _____ |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting | <input type="radio"/> Kidney Problems | <input type="radio"/> Stomach Disease | _____ |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Leukemia | <input type="radio"/> Intestinal | _____ |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Liver Disease | <input type="radio"/> Stroke | _____ |
| <input type="radio"/> Breathing Problems | <input type="radio"/> Frequent Headaches | <input type="radio"/> Low Blood | <input type="radio"/> Swelling of | _____ |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Lung Disease | <input type="radio"/> Thyroid Disease | _____ |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Mitral Valve | <input type="radio"/> Tonsillitis | _____ |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tuberculosis | _____ |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Parathyroid | <input type="radio"/> Tumors or | _____ |
| <input type="radio"/> Cold Sores/Fever | <input type="radio"/> Heart Murmur | <input type="radio"/> Psychiatric Care | <input type="radio"/> Ulcers | _____ |
| <input type="radio"/> Congenital Heart | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Radiation | <input type="radio"/> Venereal Disease | _____ |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Yellow Jaundice | _____ |

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: X _____ Date: _____