**Baywood Dental Group**
24121 Baywood Lane, Ste A
Valencia, CA 91355
Ph # : 661-291-1200
Fax # : 661-291-1266

## Patient Personal Information

| | | | | | |
|---|---|---|---|---|---|
| Title | | Nickname | | Birth Date | Age |
| Last, First | | | | Marital Status | Sex |
| Address | | | | Home # | Work # |
| | | | | Cell # | Drive Lic |
| City, State, Zip | | | | Emergency Contact | Emergency Phone # |
| Email | | | | Student | SSN |
| Health Care Guardian Name | | | | School Name | |
| Health Care Guardian Phone # | | | | Referral Type | |

## Person responsible/guarantor for paying bills

| | | | | | |
|---|---|---|---|---|---|
| Title | | Nickname | | Birth Date | Age |
| Last, First | | | | Marital Status | Sex |
| Address | | | | Home # | Work # |
| | | | | Cell # | Drive Lic |
| City, State, Zip | | | | SSN | |
| Email | | | | | |

| Do you have Primary Dental Insurance? __ Yes __ No | | | | Do you have Secondary Dental Insurance? __ Yes __ No | | | |
|---|---|---|---|---|---|---|---|
| Group No/Name | | | | Group No/Name | | | |
| Insurance Name | | | | Insurance Name | | | |
| Phone # | | | | Phone # | | | |
| Employer Name | | | | Employer Name | | | |
| Subscriber Last, First | | | | Subscriber Last, First | | | |
| Subscriber Address | | | | Subscriber Address | | | |
| City, State, Zip | | | | City, State, Zip | | | |
| Relationship to Patient | | Birth Date | | Relationship to Patient | | Birth Date | |
| Subscriber ID | | | | Subscriber ID | | | |

## Patient Medical Information

**Allergic To**

- ☐ Y ☐ N Penicillin/Amoxicillin
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates /Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetic Reaction
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Other Narcotics

**Check, if applicable**

- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Congenital Heart Defect
- ☐ Y ☐ N Contact Lenses
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes Type I (w/ Insulin)
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis A/B
- ☐ Y ☐ N Hepatitis C
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Hypoglycemia
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Jaw joint pain (TMJ Disorder)
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Pre-medicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shingles
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tonsillitis

☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N See Medications
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Autoimmune Disease
☐ Y ☐ N Bisphosphonates Use
☐ Y ☐ N Diabetes Type II
☐ Y ☐ N Diabetes Type II (w/ Insulin)
☐ Y ☐ N Eating Disorder
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Excessive Thirst
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blisters
☐ Y ☐ N Frequent Cough
☐ Y ☐ N Frequent Headaches
☐ Y ☐ N Joint Replacement Knee
☐ Y ☐ N Joint Replacement Hip
☐ Y ☐ N Joint Replacement Shoulder/Elb
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Unusual Weight Loss
☐ Y ☐ N Urinate Frequently

**Other**

☐ Y ☐ N See Scanned Documents: Pt Note

## Dental Questionnaire

### Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you regularly use dental floss ? _____

### Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

## Medical Questionnaire

### Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

### Medical Insurance

Medical Insurance Carrier _____

Medical Insurance Carrier Phone _____

Medical Insurance Carrier Subscriber Name _____

Medical Insurance Carrier Subscriber ID # _____

Medical Insurance Carrier Subscriber Birthdate _____

| Medical Questionnaire | |
|---|---|
| Family Physician | |
| Phone | |
| Are you currently under care of a Physician ? | |
| If Yes, what is the condition being treated ? | |
| Have you had any serious illness, operation or been hospitalized within the past 5 years ? | |
| If Yes, what illness or problem ? | |
| Are you currently taking any medication ? | |
| If Yes, what ? | |
| Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) | |
| Have you ever taken the diet control drug Fen-Phen ? | |
| Do you use alcoholic beverages ? | |
| Do you smoke ? | |
| **Women Only** | |
| Are you pregnant? | |
| If Yes, what is your due date ? | |
| Are you currently nursing ? | |
| Do you have menstrual period problems ? | |
| Are you on hormone replacement therapy ? | |
| Are you on birth control pills / fertility drugs ? | |
| **Additional Comments** | |
| Any Disease, Condition or Problem not Listed ? Please list | |

By signing below, I certify that all of the above information is true to the best of my knowledge.

**Patient/Guardian Signature** **Date**