Water Garden Dental
Dr. Brittany Foster
FAMILY, COSMETIC & IMPLANT DENTISTRY

Mailing Address: 3151 Airway Avenue, Suite M2
Costa Mesa, CA 92626
(Find us near the corner of Paularino and Redhill.)

Using GPS? This address will bring you right to us:
GPS Address: 319 Paularino, Costa Mesa, CA

(714) 668-9811
www.WaterGardenDental.com

PATIENT INFORMATION FORM

PATIENT

E-Mail Address: _____

Name: _____

I prefer to be called: _____ Male Female

Birthdate: _____ Age:____ SS#: _____

Home Address: _____

_____
City State Zip ~ 4

Hm # _____ Cell # _____

Wk # _____ Ext:____ Dr Lic # _____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous Dentist: _____

Last Visit Date: _____ **Reason:** _____

EMERGENCY CONTACT

Name: _____ **Relation:** _____

Phone: _____

RESPONSIBLE PARTY

Person Responsible For Account: _____

Wk #_____ Ext: ____ Hm #_____

Billing Address: _____

_____
City State Zip ~ 4

Relationship: _____ SS#: _____

Employer: _____ **Dr Lic #** _____

PRIMARY DENTAL INSURANCE

Insurance Co Name: _____

Insurance Co Phone: _____

Employer:_____

Group # (Plan, Local or Policy #): _____

Subscriber I.D.: _____

Subscriber Name: _____

Subscriber Date of Birth: ____/_____/_____

Relation to Patient: self spouse child other

SECONDARY DENTAL INSURANCE

Insurance Co Name: _____

Insurance Co Phone: _____

Employer:_____

Group # (Plan, Local or Policy #): _____

Subscriber I.D.: _____

Subscriber Name: _____

Subscriber Date of Birth: ____/_____/_____

Relation to Patient: self spouse child other

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to this Dental Office 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

MEDICAL HISTORY

Physician's Name: _____

Phone #: _____

Your current physical health is: **Good** **Fair** **Poor**

Are you currently under the care of a physician? Yes No

If so, for what condition? _____

Have you ever been hospitalized or had major surgery? YES NO

If yes, please explain: _____

Have you ever had a serious head or neck inury? YES NO

If yes, please explain: _____

_____

Are you taking any medications, pills, or drugs? YES NO

If yes, please list all medications here: _____

_____

Do you take, or have you taken, Phen-Fen or Redux? YES NO

Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? YES NO

Are you on a special diet? YES NO

Do you smoke or chew tobacco? YES NO

Do you use controlled substances? YES NO

WOMEN: Are you pregnant right now? YES NO

Are you taking oral contraceptives? YES NO

Are you nursing? YES NO

ALLERGIES: Are you allergic to any of the following? *Circle all that apply.*

Aspirin Penicillin Codeine Acrylic Metal Latex

Local Anesthetics Other (list here): _____

DO YOU HAVE OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
Angina	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Cortisone Medicine	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Genital Herpes	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Heart Pace Maker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
		Yellow Jaundice	◯ Yes ◯ No

Patient Name: _____ **Age:** _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Are you currently having any dental pain? Yes No

If yes, please explain where: _____

_____

_____

Does your jaw make noise that bothers you? Yes No

Do you clench or grind your teeth at times? Yes No

Do your jaws ever feel tired? Yes No

Does it hurt to chew or open wide to take a bite? Yes No

Do you have ear aches or pain in front of your ears? Yes No

Do you gag easily? Yes No

Does food catch between your teeth? Yes No

Are your teeth sensitive? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Any unfavorable dental experiences? Yes No

Are you happy with the color of your teeth? Yes No

Are you happy with your smile? Yes No

Your current dental health is: Good Fair Poor

How many times do you: floss/week? ____ brush/day? ____

Are your teeth sensitive to heat, cold or anything else? _____

Have you lost any teeth? Y N

Have you had hip or joint replacement surgery? Yes No

Do you require antibiotics before dental treatment? Yes No

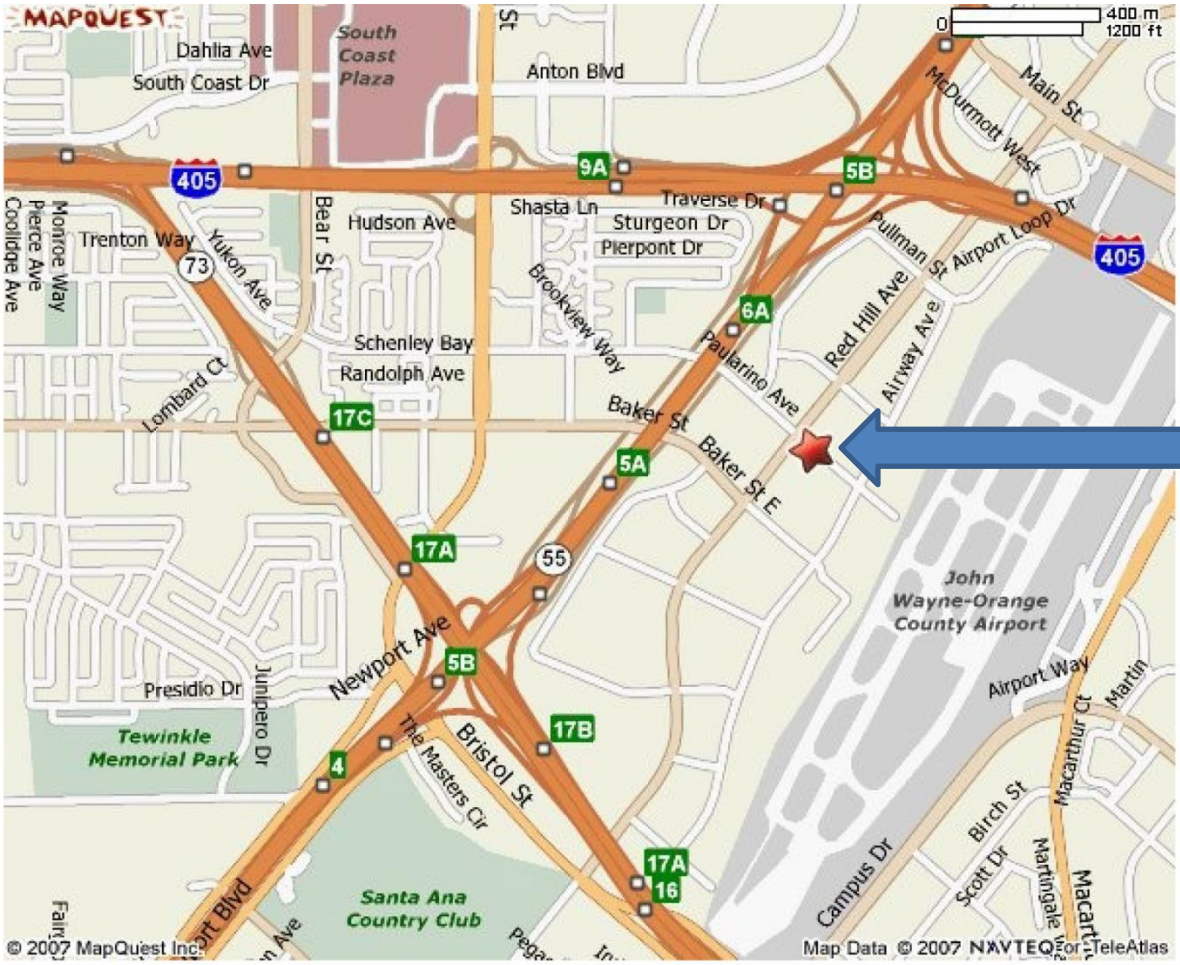
Please provide type and date of replacement surgery: _____

_____

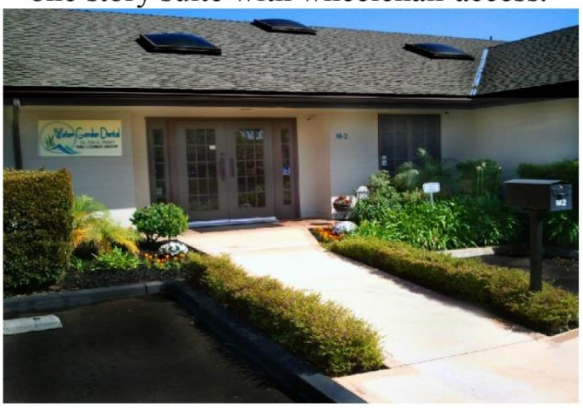
I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date



We have convenient parking in front of our one story suite with wheelchair access.



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PLEASE DON'T USE OUR MAILING ADDRESS TO FIND US!
This address will get you lost inside our business complex.

Enter WATER GARDEN DENTAL into Google Maps or Apple Maps and this should bring you to our office.

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