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?

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

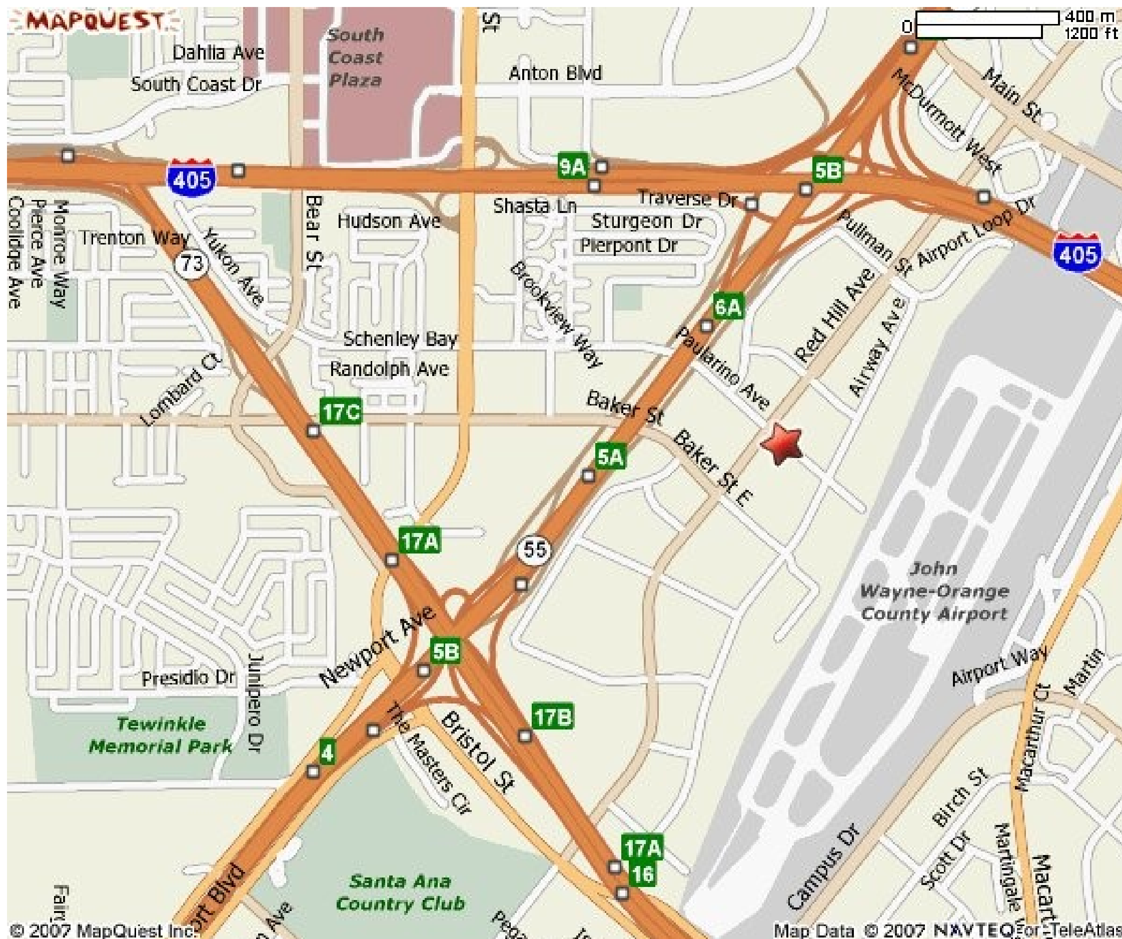
Do you require antibiotics before dental treatment? Yes No

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.

3151 Airway Avenue, Suite M2
Costa Mesa, CA 92626
714-668-9811

NOTE: Though our address says Airway Avenue, our suite actually sits on Paularino just east of Redhill in the Water Garden Suites complex.

GPS USERS should enter: 319 Paularino, Costa Mesa, CA

This alternate address will bring you closer to our suite.