Welcome To Our Practice!

Fidel Delgadillo, D. D. S.

Patient Information & Contact Information

Patient's Full Name:_____

Home:_____Cell Phone:_____

Work:_____Ext:_____

Soc. Sec#_____

Address:_____
_____

City_____State_____Zip_____

M___ F__ Age_____ Birthdate_____

Single Married Widowed Separated Divorced

Spouse's Name:_____

Soc. Security#_____Birthdate:_____

Spouse's Employer:_____

Occupation

Occupation:_____
Employer:_____

Address:_____
Employer Phone#_____

IN CASE OF AN EMERGENCY, CONTACT (Specify someone who does not live in your household).

Name:_____
Relationship:_____
Home Phone:_____
Work Phone:_____

Dental Insurance

Who is responsible for this account?_____

Relationship to Patient:_____

Subscriber's Name:_____

Birth Date:_____

Soc. Security#_____

Insurance Company:_____
Group#_____

Is the patient covered by additional insurance?
Yes__No__

Dental History

Reason for today's visit:_____
_____

Former Dentist:_____

Address:_____City/State:_____

Date of Last Dental Visit:_____

Date of last x-rays:_____

Whom may we thank for referring you?_____

Check **"yes"** or **"no"** to indicate if you have had any of the following:

Bad Breath: Yes___ No____ Burning sensation on the tongue: Yes___ No___ Periodontal treatment: Yes___ No___
Fingernail biting: Yes___ No___ Cigarette, pipe, or cigar smoking: Yes___ No__ Dry Mouth: Yes___ No___
Bleeding Gums: Yes___ No___ Loose teeth or broken fillings: Yes___ No___ Gums swollen or tender: Yes___ No___
Do you snore: Yes___ No___ Sensitivity to Hot: Yes___ No___ Sensitivity when biting: Yes___ No___
Grinding Teeth: Yes___ No___ Sensitivity to Cold: Yes___ No__ Sensitivity to Sweets: Yes___ No___
Jaw Pain or Tenderness: Yes___ No___ Clicking or popping Jaw: Yes___ No___ Orthodontic Treatment: Yes__ No___
Cigarette, pipe,or cigar smoking: Yes___ No__

Medical History

Physician's Name_____Phone_____Date of last visit_____

Have you had any serious illnesses or operations? Yes___ No___ If yes, describe_____

Are you currently under physician care? Yes__ No__ If yes, describe_____

Do you wish to talk to the dentist privately about any problem? Yes__ No__

Women: Are you pregnant? Yes__ No__ Due Date:_____ Nursing? Yes__ No__
Are you taking birth control pills?Yes__ No__

Check **"yes"** or "**no"** whether you have had any of the following:

AIDS: Yes__ No__
Alcoholism: Yes__ No__
Allergies (Pollen/Dust): Yes__ No__
Alzheimer's Disease: Yes__ No__
Anemia: Yes__ No__
Arthritis/ Gout: Yes__ No__
Artificial Heart Valve: Yes__ No__
Artificial Joints: Yes__ No__
Asthma: Yes__ No__
Blood Disease: Yes__ No__
Blood Sputum: Yes__ No__
Cancer: Yes__ No__
Chemotherapy: Yes__ No__
Cold Sores: Yes__ No__
Cough up blood: Yes__ No__
Convulsions: Yes__ No__
Cortisone Medicine:Yes__ No__
Diabetes:Yes__ No__
Drug Addiction: Yes__ No__
Excessive Bleeding: Yes__ No__
Emphysema: Yes__ No__
Epilepsy or Seizures: Yes__ No__
Fainting or Dizziness: Yes__ No__
Genital Herpes: Yes__ No__
Glaucoma: Yes__ No__
Hay Fever: Yes__ No__
Heart Attack/Failure: Yes__ No__
Heart murmur: Yes__ No__
Heart Pacemaker: Yes__ No__
High Blood Pressure: Yes__ No__
Heart Surgery: Yes__ No__
Hepatitis : Yes__ No__
Herpes: Yes__ No__
HIV Positive: Yes__ No__
Hypoglycemia: Yes__ No__
Irregular Heart Beat: Yes__ No__
Kidney Problem: Yes__ No__
Leukemia: Yes__ No__
Liver Disease: Yes__ No__
Mitral Valve Prolapse: Yes__ No_
Respiratory disease: Yes__ No__
Shingles: Yes__ No__
Sickle Cell Disease: Yes__ No__
Stroke: Yes__ No_
Thyroid Disease: Yes__ No__
Tonsillitis: Yes__ No__

Medications

List any medications you are currently taking:
_____
_____

Allergies

Aspirin__ Lodine__ Acrylic__
Penicillin__ Codeine__ Metal__
Latex Gloves__ Barbiturates__

I, the undersigned certify that I (or my dependent) understand that the above information is necessary to provide safe and efficient dental treatment. I have answered with the truth and I do not consider my dentist or the members of his staff responsible for any errors or omissions that I have made. I understand that providing incorrect information may endanger my health. I authorize and request that my insurance company pay insurance benefits directly to the dentist. I understand that it is possible that my dental insurance pays less than the total bill for the services provided. I agree to be responsible for the payment of all services provided on my behalf or my dependents. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

❌_____ Date:_____