

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT REGISTRATION INFORMATION FORMS USING YOUR KEYBOARD AND MOUSE. PLEASE PRINT, SIGN AND THEN MAIL, FAX OR BRING THE FORMS WITH YOU TO YOUR NEXT APPOINTMENT. OUR MAILING ADDRESS IS DR. ERIC CITRON 3031 TELEGRAPH AVENUE, SUITE 245, BERKELEY, CA 94705. OUR FAX NUMBER IS 510-849-1666

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL			EMAIL	
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.
- 2, Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name

DENTAL HISTORY

Patient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? YES NO

Sweets? YES NO

Biting or Chewing? YES NO

Have you noticed any mouth odors or bad tastes? YES NO

Do you frequently get cold sores, blisters or any other oral lesions? YES NO

Do your gums bleed or hurt? YES NO

Have your parents experienced gum disease or tooth loss? YES NO

Have you noticed any loose teeth or change in your bite? YES NO

Does food tend to become caught in between your teeth? YES NO

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? YES NO

Bite your lips or cheeks regularly? YES NO

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) YES NO

Mouth breathe while & wake or asleep? YES NO

Have tired jaws, especially in the morning? YES NO

Smoke/chew tobacco? YES NO

Have you ever had:

Orthodontic treatment? YES NO

Oral surgery? YES NO

Periodontal treatment? YES NO

Your teeth ground or the bite adjusted? YES NO

A bite plate or mouth guard? YES NO

A serious injury to the mouth or head? YES NO

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? YES NO

Pain? (joint, ear, side of face) YES NO

Difficulty in opening or closing the mouth? YES NO

Difficulty in chewing on either side of the mouth? YES NO

Headaches, neckaches or shoulder aches? YES NO

Sore muscles (neck, shoulders)? YES NO

Are you satisfied with your teeth's appearance? YES NO

Would you like to keep all of your teeth all of your life? YES NO

Do you feel nervous about having dental treatment? YES NO

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? YES NO

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? YES NO

3. Are you taking any medication, drugs or pills now? YES NO

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? YES NO

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? YES NO

6. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

- | | | |
|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Heart (Surgery, Disease, Attack) ... <input type="checkbox"/> YES <input type="checkbox"/> NO | Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis A (infectious) B (serum) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO | Venereal Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital Heart Disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid Problems <input type="checkbox"/> YES <input type="checkbox"/> NO | A.I.D.S. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Murmur <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO | H.I.V. Positive <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO | Contact lenses <input type="checkbox"/> YES <input type="checkbox"/> NO | Cold Sores/Fever Blisters <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mitral Valve Prolapse <input type="checkbox"/> YES <input type="checkbox"/> NO | Emphysema <input type="checkbox"/> YES <input type="checkbox"/> NO | Blood Transfusion <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Heart Valve <input type="checkbox"/> YES <input type="checkbox"/> NO | Chronic Cough <input type="checkbox"/> YES <input type="checkbox"/> NO | Hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heart Pacemaker <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO | Sickle Cell Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO | Bruise Easily <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Arthritis/Rheumatism <input type="checkbox"/> YES <input type="checkbox"/> NO | Hay Fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Liver Disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cortisone Medicine <input type="checkbox"/> YES <input type="checkbox"/> NO | Latex Sensitivity <input type="checkbox"/> YES <input type="checkbox"/> NO | Yellow Jaundice <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Swollen Ankles <input type="checkbox"/> YES <input type="checkbox"/> NO | Allergies or Hives <input type="checkbox"/> YES <input type="checkbox"/> NO | Neurological Disorders <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO | Epilepsy or Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diet (Special/ Restricted) <input type="checkbox"/> YES <input type="checkbox"/> NO | Radiation Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO | Fainting or Dizzy Spells <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial Joints (hip, knee, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO | Chemotherapy. <input type="checkbox"/> YES <input type="checkbox"/> NO | Nervous/Anxious <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Kidney Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO | Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO | Psychiatric/Psychological Care <input type="checkbox"/> YES <input type="checkbox"/> NO |

7. Do you use more than two pillows to sleep? YES NO

8. Have you lost or gained more than 10 pounds in the past year? YES NO

9. Do you have or have you had any disease, condition, or problem not listed? YES NO

If yes, please list: _____

10. Women. Are you: **Pregnant?** YES ___ Months NO **Nursing?** YES NO **Taking birth control pills?** YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____