Mt. Diablo Family Dentists
Dr. Naina Jain DMD

To meet all your healthcare needs, please fill out this form completely and accurately.

Patient #_____ SS#/SIN _____ Date _____

Patient Information (Confidential)
Name _____ Birthdate _____ Phone _____ Email _____
Address _____ City _____ State _____ Zip _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
If Student, Name of School/ College _____ City _____ State ___ ☐ Full time ☐ Part time
Patient or Parent/Guardian's Employer _____ Work Phone_____
Business Address _____ City _____ State_____ Zip _____
Spouse or Parent/Guardian's Name_____ Employer _____Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____

Responsible Party (If Patient is a minor)
Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our office? ☐ Yes ☐ No
It is customary to pay in full for services rendered. Check the payment option you prefer.
☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ AMEX ☐ Care Credit ☐ Flex Spending Account

Insurance Information
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ City _____ State _____ Zip_____
How much is your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have any additional insurance? ☐ Yes ☐ No
Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ ID# _____
Ins. Co. Address _____ City _____ State _____ Zip_____
How much is your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Patient Dental History
Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐	8. Do you have frequent headaches?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐	9. Do you clench or grind your teeth?	☐	☐
3. Are your teeth sensitive to sweet/sour foods?	☐	☐	10. Do you bite your lips or cheeks frequently?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐	11. Have you ever had any difficulty with extractions in the past?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐	12. Have you ever had prolonged bleeding following extractions?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐	13. Have you ever had orthodontic treatment?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
Clicking	☐	☐	15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums?	☐	☐
Pain (joint, ear, side of face)	☐	☐	16. Do you like your smile?	☐	☐
Difficulty in opening or closing	☐	☐			
Difficulty in chewing	☐	☐			

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	☐	☐	9. Are you allergic to or have you had any reactions to the following?		
2. Have you been hospitalized for any surgical operation or serious illness with the last 5 years? If yes, please explain:	☐	☐	➢ Local Anesthetics (e.g. Novocain) ➢ Penicillin or any other Antibiotics ➢ Sulfa Drugs ➢ Barbiturates ➢ Sedatives ➢ Iodine ➢ Aspirin ➢ Any Metals (e.g. Nickel, Mercury, etc.) ➢ Latex Rubber	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐			
4. Have you ever taken Fen-Phen/ Redux? 5. Do you use tobacco? 6. Do you use controlled substances? 7. Are you wearing contact lenses?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	➢ Other, please list:		
8. Women Only: a. Are you pregnant or think you may be pregnant? b. Are you nursing? c. Are you taking oral contraceptives?	☐ ☐ ☐	☐ ☐ ☐	10. Do you have a persistent cough or throat cleaning not associated with a known illness (lasting more than 3 weeks)?	☐	☐
			11. Do you have, or have you ever had: osteoporosis/ osteopenia (i.e. taking bisphosphonates)?	☐	☐

12. Do you have, or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other:		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payer's and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (Parent/guardian if minor)

Doctor's Comments _____

_____

Signature_____ Date _____