Family Dentistry
1307 Esplanade, Ste. 4
Chico, CA 95926
(530) 898-8511

Thank You For Choosing Us

Tell Us About You

Today's Date: ___________________________

Name: ___________________________ I prefer to be called: ___________________ ❏ Male ❏ Female

Birthdate: ___/ ___/ ___/ Age: _______ Social Security # _________________ ❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Separated

Home Address: ___________________________ City: ___________________ Zip: ___________________

Home Phone# ( ) ___________________________ Cell #: ( ) ___________________________

Work Phone # ( ) ___________________________ Driver License #: ___________________________

Email Address: ___________________________ Best place to reach you! ___________________________

Other family members seen by us: ___________________________

Referred by: ___________________________

Employer: _________________ How Long There? _________________ Occupation: _________________

Employer Address: ___________________________

Neighbor or relative not living with you

His/Her Name: _______________ Relation: ___________ Work Phone #: ( ) _______________ Home Phone#: _______________

Address: ___________________________

Person Responsible for Account if other than yourself

Name: _______________ Relation: _________ Home Phone #: ( ) ____________ Social Security #: _______________

Employer: ___________________________ Work Phone #: ( ) ______________ Drivers License #: _______________

Billing Address: ___________________________

Spouse Information

His / Her Name: ___________________________ Birthdate: ___/ ___/ ___/ Social Security #: ___________________

Employer: ___________________________ Work Phone #:( ) ______________ Drivers License#: _____________

Insurance Information

Primary Insurance

Insurance Co. Name: _________________ Phone #: _____________ Group # (Plan, Local or Policy #) _________________

Insurance Co. Address: ___________________________

Insured's Name: _______________ Insured's Social Security # : _____________ Insured's Birthdate: ___/ ___/ ___/ Relation: _________

Insured's Employer: _____________ Employer's Address ___________________________

Secondary Insurance

Insurance Co. Name: _________________ Phone #: _____________ Group # (Plan, Local or Policy #) _________________

Insurance Co. Address: ___________________________

Insured's Name: _______________ Insured's Social Security # : _____________ Insured's Birthdate: ___/ ___/ ___/ Relation: _________

Insured's Employer: _____________ Employer's Address ___________________________

Medical History

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name:________________
Address:________________
Phone #:________________ Date of last visit:________________

Your current Physical Health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please Explain:________________
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
If yes, how often?________________

Are you allergic to any of the following?

Aspirin	Y	N	Erythromycin	Y	N	Sedatives	Y	N
Barbiturates	Y	N	Jewelry	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Latex	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Penicillin	Y	N			

Please list additional drugs that cause allergic reactions:________________

For Women: Are You Taking Birth Control Pills? ❑ Yes ❑ No
Are you pregnant? ❑ Unsure ❑ Yes ❑ No
week #:________ Are you Nursing? ❑ Yes ❑ No

Are you taking any of the following?

Acetaminophen	❑ Yes ❑ No	Blood Thinners	❑ Yes ❑ No	Insulin/Diabetes Drugs	❑ Yes ❑ No	Thyroid Medicine	❑ Yes ❑ No
Antibiotics	❑ Yes ❑ No	Blood Pressure Medication	❑ Yes ❑ No	Nitroglycerine	❑ Yes ❑ No	Tranquilizers	❑ Yes ❑ No
Antihistamines	❑ Yes ❑ No	Cold Remedies	❑ Yes ❑ No	Recreational Drugs	❑ Yes ❑ No		
Asprin	❑ Yes ❑ No	Digitalis/Heart Medication	❑ Yes ❑ No	Steroids/ Cortisone	❑ Yes ❑ No		

Are you taking any prescription/over the counter drugs not listed above? ❑ Yes ❑ No If yes please list each one:________________

Have you ever taken antibiotics prior to dental treatment? ❑ Yes ❑ No
Have you ever taken Bisphosphinates? ❑ Yes ❑ No

Do you or have you experienced the following?

Abnormal Bleeding	Y	N	Congenital Heart Defect	Y	N	Heart Attack	Y	N	Lupus	Y	N	Sinus Problems	Y	N
Alcohol Abuse	Y	N	Diabetes	Y	N	Heart Murmur	Y	N	Mitral Valve Prolapse	Y	N	Stroke	Y	N
Anemia	Y	N	Difficulty Breathing	Y	N	Heart Surgery	Y	N	Pacemaker	Y	N	Thyroid Problems	Y	N
Arthritis	Y	N	Drug Abuse	Y	N	Hemophilia	Y	N	Persistant Cough	Y	N	Tonsillitis	Y	N
Artificial Bones/Joints	Y	N	Emphysema	Y	N	Hepatitis	Y	N	Psychiatric Problems	Y	N	Tuberculosis	Y	N
Artificial Valves	Y	N	Epilepsy	Y	N	High Blood Pressure	Y	N	Radiation Treatment	Y	N	Ulcers	Y	N
Asthma	Y	N	Fainting Spells	Y	N	HIV+/AIDS	Y	N	Rheumatic Fever	Y	N			
Blood Transfusion	Y	N	Fever Blisters	Y	N	Hospitalized last 2 yrs	Y	N	Scarlet Fever	Y	N			
Cancer	Y	N	Glaucoma	Y	N	Kidney problems	Y	N	Seizures	Y	N			
Chemotherapy	Y	N	Hay Fever	Y	N	Liver Disease	Y	N	Shingles	Y	N			
Colitis	Y	N	Headaches	Y	N	Low Blood Pressure	Y	N	Sickle Cell Disease	Y	N			

Please list any serious medical condition(s) that you have experienced:________________

Dental History

1. Is there anything you'd like to change about your smile?........ ❑ Yes ❑ No
   If so , explain ________________
2. Are you having discomfort at this time? Upper: ❑ Right ❑ Left Lower: ❑ Right ❑ Left........ ❑ Yes ❑ No
3. Have you ever had any unfavorable reaction from a local anesthetic (Novocaine, etc.) ? .... ❑ Yes ❑ No
4. Have you ever had any serious trouble associated with any previous dental treatment?........ ❑ Yes ❑ No
   If so, explain ________________
5. How long since your last dental treatment? ________________ Previous D.D.S. ? ________________
6. Does dental treatment make you nervous ? .... ❑ Yes ❑ No
   If YES, Check ✓: ❑ Slightly ❑ Moderately ❑ Extremely

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be________________

Date__________
Signature________________

Year 2
Changes in Health________________
Date________ Signature________________

Year 3
Changes in Health________________
Date________ Signature________________

Year 4
Changes in Health________________
Date________ Signature________________

Year 5
Changes in Health________________
Date________ Signature________________

Year 6
Changes in Health________________
Date________ Signature________________

Insurance Release

I certify that I am covered by ________________ Insurance Co. and I assign to Dr. Nelsen all insurance benefits otherwise payable to me.
I am also responsible for paying any co-payment and deductible that my insurance does not cover at time of service. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric. I understand that I am responsible for payment of services rendered.

Signature.________________ Date: ________________