Spring Valley
Dental Group

| | | |
|---|---|---|
| **Patient Name:** ☐ M ☐ F | | **Date of Birth:** |
| **If Minor – Responsible Party's Name:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Home Phone:** | **Work Phone:** | **Cell Phone:** |
| **Email:** | **Preferred Method of Contact:** ☐ | ☐ **Email** |
| **Emergency Contact:** | **Relationship:** | **Phone:** |

**Responsible Party and/or Primary Insurance Information:**
(Please notify us if there is secondary dental coverage)

| | | |
|---|---|---|
| **Relationship to Patient:** ☐ **Self** (if self, skip to insurance info) ☐ **Spouse** ☐ **Parent** ☐ **Other:** | | |
| **Responsible Party's Name or Policy Holder's Name:** | | |
| **Date of Birth:** | **Social Security Number:** | ☐ **Single** ☐ **Married** ☐ **Other** |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Work Phone:** | **Cell Phone:** |
| **Employer:** | **Occupation:** | |
| **Insurance Plan Name:** | **Insurance Group Number:** | |
| **Insurance Plan Phone Number:** | **Insurance Subscriber ID Number:** | |

**MEDICAL UPDATE**

| | |
|---|---|
| **Name of Your Physician:** | (If you do not have a physician, please write none.) |
| **Last Exam:** | **Phone Number:** |

**Women: Are you pregnant or think you could be pregnant?** ☐ Yes ☐ No **Expected Delivery Date:**

**Are you taking birth control?** ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No

**Are you under a doctor's care now?** ☐ Yes ☐ No
If so, for what reason?

_____

**Current use of any tobacco product?** ☐ None ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing tobacco ☐ Other

**Because of anesthetic, we need to know if you currently or have used any street/illicit drugs. If so, please list:**

_____

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**Patient Name:**

**Are you taking any pills, medications or prescription drugs?** ☐ Yes ☐ No

**Please List:**

**Do you have or have you ever been treated for any of the following? Please check all that apply.**

☐ AIDS/HIV
☐ Acid Reflux / GERD
☐ Allergy to ☐ Medications
☐ Anesthetic ☐ Seasonal allergies
List:

☐ Angina / Chest pain
☐ Anti-depression treatment
☐ Arthritis / Rheumatism
Type:

☐ Artificial heart valves
Date:

☐ Artificial joints
Date:

☐ Aspirin treatment / Blood thinner
☐ Asthma / Inhaler
☐ Blood disease
☐ Bruise easily
☐ Cancer
☐ Chemotherapy / Radiation therapy
☐ Chronic cough

☐ Cold sores / Fever blisters
☐ Cortisone medicine
☐ Diabetes
☐ Diet (special / restricted)
☐ Emphysema
☐ Epilepsy / Convulsions
☐ Excessive bleeding
☐ Fainting / Dizzy spells
☐ Glaucoma
☐ Hay fever / Allergy / Hives
☐ Heart (disease, attack, or surgery)
☐ Heart murmur
☐ Hemophilia
☐ Hepatitis: ☐ A ☐ B ☐ C
☐ High blood pressure or
☐ Low blood pressure
☐ High cholesterol
☐ Hormone replacement treatment
☐ Kidney trouble
☐ Latex sensitivity
☐ Liver disease / Yellow jaundice
☐ Migraines
☐ Multiple sclerosis

☐ Nervous / Anxious
☐ Neurological disorders
☐ Osteoporosis
☐ Pacemaker / Defibrillator
☐ Parkinson's Disease
☐ Psychiatric / Psychological care
☐ Respiratory Problems
☐ Rheumatic fever
☐ Sickle Cell disease
☐ Seizures
☐ Sinus problems
☐ Sexually transmitted diseases
☐ Special Needs
Type:

Functions at age:

☐ Stent (brain or spine)
☐ Stroke
☐ Substance abuse
☐ Swollen ankles
☐ Thyroid problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Use of CPAP machine /
Oral sleep device

Consent for Services/Assignment of Benefits:
After my exam, I authorize the doctor to perform the necessary treatment as needed. I authorize the release of any information relating to dental treatment to third party payers and/or other health practitioners for myself or my dependents by Spring Valley Dental Group / provider. I authorize my doctor to submit claims to be submitted for my dependents or myself. I understand that all insurance payments will be made directly to the doctor, unless otherwise specified by me.

**I have read the above conditions of treatment and agree to their contents.**

**Signature of Patient, Parent or Guardian:** **Date:**