ANCIRA FAMILY DENTAL

CLAUDIA M ANCIRA DDS

COSMETIC-IMPLANTS-RESTAURATIVE

Patient Information (Confidential)

Name_____
SS# _____ Birthdate_____
Address_____
City/State/Zip _____

Responsible Party

Name_____
Relationship to Patient _____
SS# _____ Birthdate_____
Address_____
City/State/Zip _____

Whom may we thank for referring you?

☐ Facebook ☐ Google ☐ Driving By ☐ Other:_____

Dental Insurance

Name of person responsible for account
_____
Relationship to Patient _____
SS# _____ Birthdate_____
Employer _____
Insurance Company _____
Group # _____

If patient is covered by an additional insurance, please complete the following

Name of Insured _____
Relationship to Patient _____
Insurance Company _____
Group # _____

Contact Information

Home # _____ Mobile # _____ Work # _____
Best time to contact you _____ Best phone # to contact you _____
Email: _____

In case of an emergency, whom may we contact?

Name _____ Relationship to patient _____
Home # _____ Mobile # _____ Work # _____

Dental History

Reason for today's visit _____
Former Dentist _____ Date of Last Visit _____ Date of Last Dental X-Rays_____

Acknowledgement of Receipt of *Notice of Privacy Practices*

I, _____, have received a copy of **Ancira Family Dental** *LLC.*
(Patient's Name)

Patient's/Guardian's Signature _____ Date _____

For office use only (staff will fill out this section if patient's signature is NOT obtained)

Our office made a good faith effort to obtain the Acknowledgment of Receipt of our *Notice of Privacy Practices*, but it could not be obtained for the following reason:

_____Patient Refused to sign
_____ Emergency situation kept us from obtaining the patient's signature
_____ Language barrier kept us from obtaining the patient's signature

MEDICAL HISTORY

PATIENT NAME:_____ ID#:_____
(FOR OFFICE USE ONLY)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:_____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain:_____
Do you take, or have taken, Phen-Fen or Redux? O Yes O No _____
Are you on a special diet? O Yes O No _____
Do you use tobacco? O Yes O No _____
Do you use controlled substances? O Yes O No _____

WOMEN: Are you-

Pregnant/Trying to get pregnant? O Yes O No | Taking oral contraceptives? O Yes O No | Nursing? O Yes O No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other If Yes, please explain: _____

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

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever*	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve*	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint*	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Breathing Problem	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse*	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur*	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Peace Maker*	O Yes O No	Radiation Treatment	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	O Yes O No	Recent Weight Loss	O Yes O No		O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain: _____

Comments:

_____

_____

_____

_____

*Condition may require medication

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

DATE _____

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CLAUDIA M ANCIRA DDS

COSMETIC-IMPLANTS-RESTAURATIVE

Permission for Dental Health Service and Dental Information Release

Patient Name:_____

Date of Birth: _____

Please list the individuals who you give permission to bring patient to our office for dental health service.

	Name	Relationship to Patient	Phone Number
1			
2			
3			
4			
5			

Please list the individual who you authorize to access and release the patient's dental records

	Name	Relationship to Patient	Phone Number
1			
2			
3			
4			
5			

_____ _____

Guardian's Signature Date