STEPHEN SHEPHERD, D.D.S.
REBECCA HART, D.D.S.
PERIODONTICS AND IMPLANT SURGERY
12569 Newport Ave.
Tustin, CA 92780
714-544-2220

PATIENT INFORMATION FORM

Name _____ Date of Birth _____ Age _____
Last *First*

Address _____ Home Phone _____

City _____ Zip _____ Marital Status _____ Cell Phone _____

Employer _____ Occupation _____ Bus Phone _____

Bus Address _____ City _____ Zip _____ SS# _____

Email Address _____ Drivers License No. _____

Name of Spouse _____ Date of Birth _____ SS# _____

Employer _____ Occupation _____

If patient is a minor, who is legally responsible _____ Phone _____

Referring Dentist _____ Reason for visit _____

DENTAL INSURANCE INFORMATION

Please complete the following if you have dental insurance:

Name of Insured _____ Name of Insurance Carrier _____

SS# of Insured _____ Address of Insurance Carrier _____

Date of Birth of Insured _____ Phone# of Insurance Carrier _____ Group# _____

Additional Insurance Coverage (if any):

Name of Insured _____ Name of Insurance Carrier _____

SS# of Insured _____ Address of Insurance Carrier _____

Date of Birth of Insured _____ Phone# of Insurance Carrier _____ Group# _____

It is customary that all fees for professional services be paid as treatment is rendered. Financial arrangements must be made prior to the start of treatment. We are pleased that many of our patients have insurance to help defray the cost of their dental treatment. Our office will assist you in preparing these forms and collecting from insurance companies. Please be aware insurance companies make payments based on their own time and fee schedule and that all fees for professional services are the direct responsibility of the patient.

HEALTH HISTORY

The following questions are all associated with the proper management of your oral health. **Our office should be notified of any changes in your health.** Your answers are for our records only and will be considered confidential.

1. Are you in good health? YES NO
   If no, what is nature of illness? _____
2. Physicians name _____ Specialty _____
   Address and telephone _____ Date of last physical examination _____
3. Women: Are you pregnant or possibly pregnant at this time? YES NO
4. Have you ever been instructed to take antibiotic pre-medication before dental treatment? YES NO

Have you ever had any of the following conditions?

Damaged heart valves, artificial valves, pacemaker, artificial arteries or grafts	YES	NO
Asthma	YES	NO
Congenital heart defect or heart murmur	YES	NO
Cardiovascular disease, heart attack, high blood pressure, stroke or cardiac insufficiency	YES	NO
Artificial joints or surgically placed prosthesis, including hip or knee joints	YES	NO
History of bleeding, blood disorders or anemia	YES	NO
Have you ever taken oral drugs called bisphosphonates for osteoporosis, for example, Fosamax, Actonel, Boniva	YES	NO
Have you ever had intravenous bisphosphonate medication, for example Zometa, Reclast	YES	NO
Seizures or epilepsy	YES	NO
Diabetes or blood sugar problems (if yes, blood sugar _____)	YES	NO
Liver disease, history of jaundice or hepatitis	YES	NO
Kidney Disease	YES	NO
History of smoking: Amount per day _____ Number of years _____	YES	NO
Alcoholism, drug use or dependence	YES	NO
Immune compromises, including HIV, ARC, or AIDS	YES	NO
Have you ever had treatment for cancer including x-ray treatment or chemotherapy	YES	NO
Do you have any disease, conditions or problems other than those listed above? _____	YES	NO
If yes, what? _____		

Are you allergic or have you had any adverse reaction to any of the following medications:

Penicillin or other antibiotics	YES	NO	Aspirin or Ibuprofen	YES	NO
Sulfa drugs or Iodine	YES	NO	Codeine or other narcotic medications	YES	NO
Local anesthetics	YES	NO	Valium, sedatives, or sleeping pills	YES	NO
Latex	YES	NO	Other _____	YES	NO

Are you currently taking any of the following medications:

Antibiotics	YES	NO	Anticoagulants (blood thinners)	YES	NO
Blood pressure medication	YES	NO	Steroids	YES	NO
Osteoporosis medication	YES	NO	Tranquilizers	YES	NO
Aspirin, Ibuprofen, or Naproxen	YES	NO	Digitalis, Nitroglycerine or other heart medication	YES	NO
Oral contraceptives	YES	NO	Insulin or other blood sugar altering medication	YES	NO

List all medications that you take _____

I understand that withholding any information about my health could seriously jeopardize my safety. I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

_____ _____

Signature of Patient (or legal guardian) **Date**