Date_____

Patient Information

Name _____ Date of Birth_____
Last Name First Name Middle Initial

Home Phone ( )_____ Cell phone( )_____

Address _____ City_____ State____ Zip_____

Sex M ___ F_____ Age_____ SS#_____ ___ Married ___Widowed ___Single ___ Minor ___Separated ___Divorced

Patient Employer/School_____ Employer/School Phone ( )_____

E-Mail_____

Whom may we thank for referring you?_____
In case of emergency who should be notified? _____phone( )_____

Person Responsible for Account (Parent of a child) *Leave blank if same as patient*

_____
Last Name First Name M.I.

Relation to patient _____ Birth Date _____ Soc. Sec. #_____

Phone ( )_____
Address if different from above _____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Work ph# _____

Patient name_____ **DOB**_____

Dental History

Reason for today's visit_____ Date of last dental care_____

Former dentist_____ Date of last dental X-Ray_____

Check if you have had any problems with the following:

___ Bad breath ___ Grinding teeth ___Sensitivity to hot ___Food collection between teeth

___Bleeding gums ___Loose teeth or broken fillings ___Sensitivity to sweets ___Sensitivity to cold

___Clicking or popping jaw ___Periodontal treatment ___Sensitivity when biting ___Sores in mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's name _____ Phone ( ) _____

Have you had any medical care within the past two years? ..... Yes No

Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No

If yes, please list name and dosage_____

Have you ever taken prescription medications for weight loss (diet pills) ?..... Yes No

If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other

If yes to any of the above, did you have a medical exam for heart issues? ..... Yes No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ..... Yes No

Have you been a patient in the hospital in the past five years? ..... Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack).	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle).....	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease ...	Yes	No	Thyroid problems	Yes	No	A.I.D.S/H.I.V. Positive	Yes	No
Heart murmur	Yes	No	Glaucoma	Yes	No	Cold sores/Fever blisters	Yes	No
High/Low blood pressure	Yes	No	Contact lenses	Yes	No	Blood transfusion	Yes	No
Mitral valve prolapsed	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial heart valve/pacemaker. .	Yes	No	Chronic cough	Yes	No	Sickle cell disease	Yes	No
Rheumatic fever	Yes	No	Tuberculosis	Yes	No	Bruise easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver disease/Yellow Jaundice	Yes	No
Cortisone medicine	Yes	No	Hay fever/Allergy/Hives ...	Yes	No	Neurological disorders	Yes	No
Swollen ankles	Yes	No	Latex allergy	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus trouble	Yes	No	Fainting or dizzy spells	Yes	No
Diet (special/restricted)	Yes	No	Radiation therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological care	Yes	No
Kidney trouble	Yes	No	Tumors	Yes	No			

Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No

Have you lost or gained more than 10 pounds in the past year? ..... Yes No

Do you have or have you had any disease, condition or problem not listed? ..... Yes No

If you answered yes to any above, please list: _____

Women: Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** Yes No

Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

ProDENTAL
A Professional Dental Corp
website: yourprodental.com
Tel:530-534-6666

Patient Consent Form

1. I hereby give my permission to Dr. Pham to render such dental services and/or oral surgery deemed necessary.

2. I am aware that during the course of treatment, conditions may require dental procedures in addition to or different from those planned. I consent to such changes when the doctor deems it necessary or advisable.

3. I am in agreement with the doctor and consent that she may prescribe the medications she deems necessary.

4. As with all dental procedures, I understand that there is a potential risk involved.

5. I have received a copy of the Dental Materials Fact Sheet.

Authorization

I certify that I and/ or my dependent(s) have insurance coverage. I assign directly to Dr. Pham/ Prodental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Patient/Guardian Signature **Date**

ProDENTAL
A Professional Dental Corp
website: yourprodental.com
Tel:530-534-6666

Re schedule/Cancellation Policy

This time is reserved just for you. If you are unable to keep your appointment, please notify us at least 48 hours in advance so that we may schedule a new time for you.

There will be a $45 charge for no show appointments, or reschedule/cancellation appointment without 48 hours notice.

If you fail to show for your appointment 2 times, we may have the right to cancel the rest of your appointments and dismiss you from our office.

Please arrive 10 minutes before your scheduled appointment, to allow time to check in.

Thank you for your consideration

_____ _____

Patient Signature/ Guardian Signature Date

_____ _____

Patient Name/ Guardian Name (Please Print) Date

Our office is located at:
2630 Olive Highway, Suite A, Oroville, CA 95966
Phone: 530-534-6666 Fax: 530-534-1040