Please complete our confidential patient registration forms with your keyboard and mouse. Please print, sign, and then mail, fax, or bring the forms with you to your next appointment. Our mailing address is Robert L Simon, DDS, 1321 N. Harbor Blvd. Suite 203 Fullerton, CA 92835 Our fax number is : (714) 525-5998

PATIENT INFORMATION

Referred by: ☐ A friend _____ ☐ Dr._____

☐ Yellow pages ☐ Something in the mail ☐ Dental society ☐ Other (please describe)

_____

Patient's name (Mr. Dr. Mrs. Ms.) _____

☐ ☐ ☐ ☐

Address _____

City:_____Zip:_____ Date of birth:_____

Home phone _____Work phone: _____

Name of Spouse:_____ Best appointment times: _____

Social Security:_____Driver's license:_____

INSURANCE INFORMATION

Primary carrier:_____ Group #_____

Claims sent to:_____

Employer:_____Address: _____

Employee name:_____Social Security: _____

Relation to patient: _____ Date of birth:_____

Secondary carrier:_____ Group # _____

Claims sent to:_____

Employer:_____Address: _____

Employee name:_____Social Security: _____

Relation to patient: _____ Date of birth:_____

HEALTH QUESTIONNAIRE

NAME _____Date of Birth_____

WHAT IS YOUR DENTAL PROBLEM_____

LAST DENTIST YOU SAW Dr._____City _____

DATE OF LAST PROFESSIONAL CLEANING_____

WHAT MEDICATIONS DO YOU TAKE DAILY?

_____
_____
_____
_____

PHYSICIAN'S NAME Dr. _____City _____

☐ Yes ☐ No Are you having pain or discomfort at this time?

☐ Yes ☐ No Have you been a patient in a hospital in the past year?

☐ Yes ☐ No Have you ever taken Phen-fen?

☐ Yes ☐ No Have you been under the care of a physician in the past year?

For what condition?_____

☐ Yes ☐ No Are you allergic or made sick by any drugs or medications?

☐ latex ☐ penicillin ☐ sulfa

☐ Other_____

☐ Yes ☐ No Have you ever had any excessive bleeding requiring special treatment?

☐ Yes ☐ No When you walk up stairs do you ever have chest pain?

☐ Yes ☐ No Do your ankles swell during the day?

☐ Yes ☐ No Have you ☐ **lost or** ☐ **gained** more than 10 pounds in the last year?
(if yes, check one)

☐ Yes ☐ No Are you on a special diet?

☐ Yes ☐ No Has a medical doctor ever said you have cancer or a tumor?

☐ Yes ☐ No WOMEN: Are you pregnant? Due date_____

HEALTH QUESTIONNAIRE

HAVE YOU HAD ANY OF THE FOLLOWING:

☐ Heart disease	☐ Tuberculosis	☐ Hay fever	☐ Jaundice
☐ High blood pressure	☐ Emphysema	☐ Liver disease	☐ Hepatitis
☐ Heart attack	☐ Chronic cough	☐ Asthma	☐ Angina
☐ Sinus trouble	☐ Allergies	☐ Hemophilia	☐ Stroke
☐ Blood transfusion	☐ Hives	☐ Thyroid disease	☐ Diabetes
☐ Drug dependence	☐ Cold sores	☐ Chemotherapy	☐ Epilepsy
☐ Heart murmur	☐ Arthritis	☐ Venereal disease	☐ Fainting
☐ Artificial heart valve	☐ Pain in jaws	☐ Dizzy spells	☐ Seizures
☐ Heart pacemaker	☐ Glaucoma	☐ Bruise easily	☐ HIV
☐ Heart surgery	☐ Artificial joint	☐ Anemia	
☐ Nervousness	☐ Ulcers	☐ Kidney trouble	
☐ Mental retardation	☐ Cerebral palsy		

ANY DISEASE, CONDITION OR PROBLEM WE SHOULD KNOW ABOUT BUT NOT MENTIONED ABOVE?_____

To the best of my knowledge, all the preceding answers are true. If there is a change in your health or medications please inform this office.

SIGNATURE of Patient_____Reviewed by_____
(parent or guardian)

On dates following the initial visit:

Date_____ ☐ Yes ☐ No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?

_____

Date_____ ☐ Yes ☐ No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?

_____

Date_____ ☐ Yes ☐ No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?

_____