Patient Information

Dr Bonnie Bateman DDS
Dr Rebekah Coraity DDS
Dr Gary Trombatore DDS

Name _____
Address_____
City_____ State_____ Zip_____
Date of Birth_____ Age_____
Male_ Female _
Social Security #_____
Driver's License #_____
Married_ Single_
Employer_____
Address_____
Position_____

Home#_____
Work# _____
Cell #_____
Email Address:_____

Spouse Information

Name_____ DOB _____
Social Security #_____
Employer #_____
Address _____
Phone#_____ Position _____

*If you have Dental Insurance, please provide the following information so we can assist you in billing your dental insurance carrier:

Primary Carrier

Name of Insured_____
Patient Relationship to Insured_____
SS# or Member ID_____
Insurance Carrier_____
Employer _____
Group #_____

Secondary Carrier

Name of Insured_____
Patient Relationship to Insured_____
SS# or Member ID_____
Insurance Carrier_____
Employer_____
Group#_____

General Information

Person Responsible for Account_____
Relationship to Patient_____
Driver's License #_____
Person to contact in case of emergency :
_____
Their Telephone_____

How did you hear about the office?

_____

Please Fill out Both Sides

Los Altos Dental: 2618 Los Coyotes Diagonal, Long Beach, CA 90803

Medical History

Please Answer All Questions

Please circle Yes or No to the following:

If Yes, Explain:

Rheumatic Fever	NO	YES_____
Heart Murmur	NO	YES_____
High Blood Pressure	NO	YES_____
Circulation Problems	NO	YES_____
Excessive Bleeding	NO	YES_____
Hepatitis	NO	YES_____
Venereal Disease	NO	YES_____
AIDS	NO	YES_____
Anemia	NO	YES_____
Diabetes	NO	YES_____
Kidney Disease	NO	YES_____
Respiratory Disease	NO	YES_____
Tuberculosis	NO	YES_____
Sinus Problems	NO	YES_____
Asthma	NO	YES_____
Hay Fever	NO	YES_____
Ulcers	NO	YES_____
Arthritis	NO	YES_____
Tumors or Growths	NO	YES_____
Radiation Treatment	NO	YES_____
Fainting Spells	NO	YES_____
Nervous Disorders	NO	YES_____
Epilepsy	NO	YES_____
Head/Neck Injuries	NO	YES_____
Stroke	NO	YES_____

Are you in good health?_____

Date of Last medical Exam_____

Have you ever been Hospitalized?_____

If yes, what was the reason_____

Do you wear a cardiac pacemaker?_____

Are you under the care of a physician?

_____

If so, for what?_____

Are you Pregnant?_____

How many months?_____

List any drugs or chemicals you are sensitive to_____

Any allergies to latex?_____

List any drugs you are now taking

_____

Have you ever taken Bisphosphonates?_____

Physician's name_____

Do you have any other disease, problem Or condition that you think the Doctor should know about?_____

_____

Do you smoke?___ If yes, How many packs a day/ for how long?_____

Do you drink alcohol? If yes, what is your weekly intake?_____

Dental History

(Please Answer All Questions)

When was the last time you saw a Dentist?_____

Have you ever had an unfavorable experience with a Dentist?_____

_____

Is there anything we can do to make you feel more comfortable While receiving treatment?

_____ Nitrous Oxide

_____Stereo Headphones

_____ Other_____

When were your last set of x-rays taken?_____

Have you been instructed in the care of your gums?

_____

Have you been treated for periodontal (gum) disease?_____

Do you have any sores, blisters, or swelling on your gums, lips, cheeks?

_____

Do you grind/clench your teeth?_____

Have you ever had any popping or clicking near your ear when you chew?_____

Have you had orthodontic treatment?_____

Do you, or have you had any dental Diseases/ problems that haven't been Mentioned?_____

Explain:_____

I authorize the dentist to perform . diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.

Patient or Guardian's Signature:_____ Date _____

I certify that I have reviewed the medical history with the patient:_____ Date _____

Doctor's signature