J. C. ROMERO D.D.S.
FAMILY DENTISTRY

# Welcome – Tell Us About Yourself

Name: ______________________________________________________________
Last First MI Title

Preferred Name: ____________________________________________ Male/ Female

Address: __________________________ City ____________ State ______ ZIP_________

SSN: ___________________________ DOB: ________________________________

Home Phone: _______________________ Work Phone: ___________________________

Cell Phone:________________________ E-mail Address: _________________________

Employer:__________________________ Occupation: ___________________________

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widowed ☐Separated ☐ Domestic Partner

**IN CASE OF EMERGENCY, CONTACT:** Name:_____________________ Relationship :________

Home Phone:_________________________ Cell Phone:_____________________________

How did you hear about our office?______________________________________________

Do you prefer to be contacted for appointment confirmation via: phone /text. ***(Please circle preference)***

## Insurance – Primary

Subscriber Name: _________________ Relationship to Patient: ________ Subscriber DOB: ________

Subscriber SSN/ID: ____________________ Subscriber Employer: _____________________

Insurance Company Name: ______________________________________________________

Insurance Company Address:_____________________________________________________

Insurance Company Phone: _______________ Group Number: _________________________

## Insurance – Secondary

Subscriber Name: _____________________ Relationship to Patient: ________ Subscriber DOB: ________

Subscriber SSN/ID: ____________________ Subscriber Employer: __________________________

Insurance Company Name: __________________________________________________________

Insurance Company Address:_________________________________________________________

Insurance Company Phone: _______________ Group Number: _____________________________

## Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. J. C. Romero 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____________________________________________________

Relationship: ______________________________ Date: ______________________________

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PATIENT NAME: ______________________________ (PREFERRED): ______________________

# Health Information

**Have you ever had or have any of the following? Please check those that apply:**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Congenital Heart Lesion
- ☐ Cortisone Treatment
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Glaucoma
- ☐ Heart Disease/Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung/Pulmonary Disorder
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Smoke/Chewing Tobacco
- ☐ Blood Thinners
- ☐ Dialysis
- ☐ Other: _________________

## Allergies

- ☐ Latex
- ☐ Aspirin
- ☐ Barbiturates/Sleeping Pills
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetic
- ☐ Penicillin/Amoxicillin
- ☐ Sulfa
- ☐ Other: _________________

**Women:**

- ☐ Are you Pregnant?
  Due Date: ___________
- ☐ Are You Nursing?

## Medications

| |
|---|
| |
| |
| |

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:
  ________________________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:________________________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:________________________________________________
- Name of Physician: ______________________________ Phone:____________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

________________________________________________ ____________________

*Signature of patient, parent or guardian* *Date*

Reviewed By: ________________________________________ ____________________

*Date*

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# Dental History Form

PATIENT NAME: (PREFERRED): DATE:

**Please describe the primary reason for your visit (concerns):**

1.______________________________
2.______________________________
3.______________________________

**4. How long has this been going on and what would you like done?**

______________________________
______________________________

**5. If you could rate your smile from 1 - 10, what would it be?** ______________________________

**6. Is there anything about your smile you would like to improve? Y N What?**______________________________
______________________________

**7. When was your last dental cleaning?** ______________________________
**8. When was your last dental visit?** ______________________________
**9. Why did you leave your previous dentist?** ______________________________
**10. How can we accommodate you better during your dental visit?**______________________________

**Have you ever suffered from, or been told you may have any of the following?**

| | | | |
|---|---|---|---|
| 7. Gum disease | Y N | 11. Malocclusion/Bad Bite | Y N |
| 8. Bruxism or Grinding | Y N | 12. Bad Breath | Y N |
| 9. Jaw pain or TMJ | Y N | 13. Headaches or Migraines | Y N |
| 10. Dental pain | Y N | 14. Tooth Sensitivity to Hot/Cold | Y N |

**DOCTOR'S NOTES:** ______________________________
______________________________
______________________________