

# John Ruzzamenti, DDS

41530 Enterprise Circle South ~ Suite 119 ~ Temecula, CA ~ 92590 (951) 296-3358

Please answer all questions on **both** sides, so we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Male  Female Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Phone No ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail \_\_\_\_\_  
Previous Address (if less than one year)  
 Married  Single  Divorced  Separated  Widowed  
Name Of Spouse \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security No. \_\_\_\_\_  
Patient Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Spouse Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

## Primary Dental Insurance

## Secondary Dental Insurance

Employee \_\_\_\_\_  
Relationship To Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Group # \_\_\_\_\_  
Billing Address \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Employee's S.S. No. \_\_\_\_\_  
Subscriber DOB \_\_\_\_\_

Employee \_\_\_\_\_  
Relationship To Patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Group # \_\_\_\_\_  
Billing Address \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Employee's S.S. No. \_\_\_\_\_  
Subscriber DOB \_\_\_\_\_

### PAYMENT IS EXPECTED AT TIME OF EACH VISIT

PLEASE CHECK METHOD OF PAYMENT:

Cash  Check  Bankcard  Insurance

Person responsible for payment \_\_\_\_\_

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (other than spouse)

Name \_\_\_\_\_ Home Phone No. ( ) \_\_\_\_\_ Work Phone No. ( ) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### HEALTH HISTORY

(Office Use Only)

Today's Date: _____	Patient's Signature: _____	Today's Date: _____	Patient's Signature: _____
Update Date: _____	Patient's Signature: _____	Update Date: _____	Patient's Signature: _____
Update Date: _____	Patient's Signature: _____	Update Date: _____	Patient's Signature: _____

## DENTAL HISTORY

- Are you nervous about having dental treatment?  Yes  No
- Have you ever had a bad dental experience?  Yes  No
- Do you have difficulty or pain when opening (yawning)?  Yes  No
- Does your jaw get stuck, locked, or "go out"?  Yes  No
- Difficulty / pain when chewing, talking or using your jaws?  Yes  No
- Do you have noises in your jaw joints?  Yes  No
- Pain about the ears, temples or cheeks?  Yes  No
- Does your bite feel uncomfortable or unusual?  Yes  No
- Have you had a recent injury to your head / jaw?  Yes  No
- Have you been treated for jaw joint problem?  Yes  No
- Chief dental concern: \_\_\_\_\_

- Do your teeth ever feel loose?  Yes  No
- Does your food catch in-between your teeth?  Yes  No
- Do your gums ever bleed?  Yes  No
- Any difficulty chewing your food?  Yes  No
- Have you ever had periodontal disease?  Yes  No
- Are your teeth sensitive to cold / heat / etc?  Yes  No
- Have you ever been premedicated w/antibiotics for dental work?  Yes  No
- Do you have frequent Headaches?  Yes  No
- Previous Dentist's Name \_\_\_\_\_
- Are you happy with the way your teeth look?  Yes  No
- If not, what would you change? \_\_\_\_\_

## HEALTH HISTORY

- Are you having any pain or discomfort at this time?  Yes  No
- Do you smoke or use tobacco in any form?  Yes  No
- Have you been hospitalized in the past 2 years?  Yes  No
- Have you been under the care of a medical doctor during the past 2 years?  Yes  No
- Physician Name \_\_\_\_\_
- Address \_\_\_\_\_ Phone \_\_\_\_\_

- Are you currently taking any medications / drugs?  Yes  No
- If yes, please list: \_\_\_\_\_
- Have you ever taken Phen/fen, Redux or related drugs?  Yes  No
- If yes, please list: \_\_\_\_\_
- Women: Are you pregnant?  Yes  No
- Please list any serious medical condition(s) that you have/had: \_\_\_\_\_

Please Check (✓) any of the following which you have now or have had in the past?

- |  |  |
|--|--|
| <input type="checkbox"/> Angina Pectoris                 | <input type="checkbox"/> Cosmetic Surgery                    |
| <input type="checkbox"/> Heart Disease / Attack / Stroke | <input type="checkbox"/> Emphysema / Asthma                  |
| <input type="checkbox"/> Heart Failure                   | <input type="checkbox"/> Cough / Tuberculosis (TB)           |
| <input type="checkbox"/> High / Low Blood Pressure       | <input type="checkbox"/> Arthritis / Rheumatism              |
| <input type="checkbox"/> Congenital Heart Defect         | <input type="checkbox"/> Cortisone Medicine                  |
| <input type="checkbox"/> Heart Murmur / Rheumatic Fever  | <input type="checkbox"/> Venereal Disease                    |
| <input type="checkbox"/> Heart Surgery                   | <input type="checkbox"/> A.I.D.S. / H.I.V.                   |
| <input type="checkbox"/> Heart Pacemaker                 | <input type="checkbox"/> Hepatitis: A (infectious) B (scrum) |
| <input type="checkbox"/> Artificial Heart Valve          | <input type="checkbox"/> Frequent Headaches                  |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Pain in Jaw Joint                   |
| <input type="checkbox"/> Blood Transfusion / Anemia      | <input type="checkbox"/> Artificial Joints (Hip, Knees)      |
| <input type="checkbox"/> Sickle Cell Disease             | <input type="checkbox"/> Scarlet Fever                       |
| <input type="checkbox"/> Bruise Easily                   | <input type="checkbox"/> Fever Blisters / Cold Sores         |
| <input type="checkbox"/> Hemophilia                      | <input type="checkbox"/> Fainting / Dizzy Spells             |
| <input type="checkbox"/> Liver Disease / Yellow Jaundice | <input type="checkbox"/> Epilepsy / Seizures / Convulsions   |
| <input type="checkbox"/> Kidney Failure / Dysfunction    | <input type="checkbox"/> Hay Fever / Sinus Trouble           |
| <input type="checkbox"/> Thyroid / Parathyroid Disease   | <input type="checkbox"/> Allergies / Hives                   |
| <input type="checkbox"/> Ulcers / Stomach or Duodenal    | <input type="checkbox"/> Shingles                            |
| <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Nervousness                         |
| <input type="checkbox"/> Chemotherapy / Cancer           | <input type="checkbox"/> Psychiatric Treatment               |
| <input type="checkbox"/> X-ray / Cobalt Treatment        | <input type="checkbox"/> Drug / Alcohol Addiction            |

Are you allergic or have you reacted adversely to any of the following?

- Please Circle*
- |  |   |
|--|---|
| • Aspirin                                | • Penicillin                                  |
| • Darvon                                 | • Erythromycin                                |
| • Codeine                                | • Tetracycline                                |
| • Demerol                                | • Other Antibiotics                           |
| • Percodan                               | • Latex                                       |
| • Valium                                 | • Metal / Jewelry                             |
| • Scopolamine                            | • Nitrous Oxide                               |
| • Sleeping Pills<br>(Nembutal / Seconal) | • Local Anesthetic<br>(Novocaine / Xylocaine) |
- Are you aware of being allergic to any other medications or substances? If yes, please list: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Signature \_\_\_\_\_

Date \_\_\_\_\_