MARIN ADVANCED
DENTAL CARE

Date: _____

**Patient Information**

Name: _____ SS#:_____ Drivers Lic. #:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Mailing Address: _____

Email Address: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Emergency Contact: _____ Phone #: _____

Whom may we thank for referring you? _____

**Insurance Information**

Name of Ins. Company: _____ Phone #:_____

Primary Subscriber: _____ DOB: _____ SS#:_____

Relation to patient: _____ Employer Name: _____

Member ID#:_____ Group#:_____
Please check if you have additional insurance information ☐

**Dental History**

How can we make today a successful visit? _____
How long ago was your last dental visit? _____
What is the funniest movie you have seen? _____
Are you happy with your smile? _____ Would you like straighter teeth? _____

Check (✓) if you have had problems with any of these following:

| | | |
|---|---|---|
| ☐ Bad Breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Bleeding Gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal Treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ Sores or growths in your mouth |

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

**Please complete the back.**

## Medical History

Primary Physician's name:_____ Phone #: _____ Last visit: _____

**Have you ever used a Bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ yes ☐ no**

**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 had any serious illnesses or operations? ☐ yes ☐ no If yes, describe:**_____
_____

**Have you ever had a blood transfusion? ☐ yes ☐ no If yes, give approx. dates:** _____
_____

**(Women) Are you pregnant? ☐ yes ☐ no Nursing? ☐ yes ☐ no Taking Birth Control ☐ yes ☐ no**

### Check (✓) if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hepatitis (circle) A B C | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV/ AIDS | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Limbs |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer type_____ | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

### Medications: List medications you are currently taking and reasons why

_____
_____

### Has your primary care physician advised you to pre-medicate or take blood thinners? If yes, please list any of the prescribed medications:

_____
_____

### Allergies:

_____
_____

### Authorization

**I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

**Signature of Patient/ Legal Guardian:**_____ **Date:**_____