7035 N. Chestnut Ave, Suite 107, Fresno, CA 93720

Name: ____
Last First Middle Initial Title

Preferred Name: ______________________________ ☐ Male ☐ Female

Address:_______________________________ City:______________ State:____ Zip: ________

SSN:__________________________________ DOB: ______________________________

Home Number:___________________________ Work Number: ________________________

Cell Phone: ____________________________ Email address: ______________________

Employer: ______________________________ Occupation: _________________________

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

How did you hear about our office? ____

How do you prefer to be contacted? ☐Email ☐Phone

INSURANCE INFORMATION: Not covered by Dental Insurance? ☐

◆Insurance Primary◆

Subscriber Name:_________________________ Relationship to Patient: __________________

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 & Release◆

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to iTooth Dentistry 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: ____________________________

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature: ____

Medical History

Do you have a personal physician? ☐ Yes ☐ No
Physician's Name: ____
Physician's Phone: ____
Date of Last Visit: ____
Your current Health is? ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: ____
Do you use tobacco in any form? ☐ Yes ☐ No
Have you had any metal rods, pins, or implants placed? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
Please list each one: ____
____
Have you ever had any surgical procedures? ☐ Yes ☐ No
Please list each one:____
If female, please answer the following:
Are you taking Birth Control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No If so, how many weeks? __________________
Are you nursing? ☐ Yes ☐ No

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Angina Pectoris
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Arthritis
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV / AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Ibuprofen
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sedatives
☐	☐	Sulfa drugs
☐	☐	Tetracycline

Emergency Contact:
Nearest Relative Not living with you: ____

Relationship:____Phone: _________________________

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, iTooth Dentistry, of any changes in my medical status.

Signature:____ Date: _____________