Rock 'N' Roll™
DENTAL
ETHAN HARRIS DMD, INC.

2301 Camino Ramon, Suite 294
San Ramon, CA 94583
925-557-7022

WELCOME

Our goal is to give you the most professional and up to date care available in a relaxing and friendly environment. If there is anything we can do to make your experience better please let us know.

PATIENT INFORMATION

Patient name _____ Nickname _____Date _____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

Best daytime contact number (_____) _____

Employer _____ Occupation _____

Employer Address _____ City _____ State_____ Zip _____

Social Security Number _____ Male____ Female____ Date of Birth_____

____ Single ____ Married: Spouse/ Partner's Name _____ Children _____

In Case Of Emergency Contact_____

_____

Relationship _____ Phone_____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Insurance Company _____

Complete Insurance Address _____

Insurance Phone Number (_____) _____ Group Number _____

Do you have any secondary insurance? _____

Name of insured if other than yourself? _____

Relationship_____ Date of Birth _____ Social Security Number _____

Employer _____

I, the undersigned, (or my dependent), certify that I have the insurance coverage above and assign directly to Dr. Harris all dental insurance benefits. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance.

Responsible Party Signature _____

Relationship _____ Date _____

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HEALTH HISTORY

NAME _____DATE: _____

Are you in good health now? _____Are you under the care of a physician? _____

Physicians name _____ Phone Number (____) _____

Date of last physical _____Abnormal findings? _____

Describe_____

Have you seen a dermatologist? _____How often?_____

Please list any hospitalizations and surgeries you have had

_____

_____

Any complications? _____

Have you ever had a blood transfusion? _____

(Women) Are you pregnant? _____ Nursing? _____

(Women) Do you see a GYN yearly? _____

DO YOU HAVE HAD ANY OF THE FOLLOWING: PLEASE CIRCLE YES OR NO

Heart Murmur	YES	NO
Asthma	YES	NO
Ulcers / Esophageal reflux	YES	NO
Chest Pain	YES	NO
Dizziness / Fainting	YES	NO
Bruise easily	YES	NO
Pacemaker	YES	NO
Marked weight change	YES	NO
Osteoporosis	YES	NO

Is there anything else about your health we should be aware of?

_____

Do you, or have you used any tobacco products? PLEASE CIRCLE YES OR NO:

YES NO

How much? _____

For how long? _____ Do you have more than 2 alcoholic drinks a day? YES NO

Have you used addictive or controlled substances? YES NO

Have you used Fenphen? YES NO

Have you used Bisphosphonates? (Examples: Fosamax, Boniva, Zometa, Actonel.) YES NO

If so, how long did you use these medications?

Have you been evaluated by a cardiologist? YES NO

Do you have any health care providers you feel are exceptional that we might use for referrals? _____

_____

Would you like any specialist referrals?	YES	NO
If yes, would you like a referral to a nutritionist?	YES	NO
Would you like a referral to a plastic surgeon / Med Spa	YES	NO

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LIST ANY MEDICATIONS YOU ARE TAKING:

Medication_____**Purpose**_____

Medication_____**Purpose**_____

Medication_____**Purpose**_____

Medication_____**Purpose**_____

Medication_____**Purpose**_____

DO YOU HAVE ANY ALLERGIES ? **YES** **NO**

PLEASE CIRCLE ANY ALLERGIES YOU HAVE

Aspirin
Ibuprofen
Tylenol
Barbiturates
Codeine
Sulfa
Local anesthetics
Penicillin
Other _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO.

Tuberculosis	YES	NO
Hepatitis / Jaundice	YES	NO
Artificial valves	YES	NO
Epilepsy / convulsions	YES	NO
Frequent / Pain – urinating __ Shortness of breath	YES	NO
Arthritis / Rheumatism	YES	NO
HIV / AIDS	YES	NO
Artificial joints / metal __ Rheumatic fever	YES	NO
Stroke	YES	NO
Mitral valve prolapse	YES	NO
Persistent cough	YES	NO
Upper or Lower GI disease	YES	NO

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Heart Attack	YES	NO	
Diabetes	YES	NO	IF YES, TYPE 1 OR TYPE 2?
Headaches	YES	NO	
Kidney Disease	YES	NO	
High Blood Pressure	YES	NO	
Endocrine disease	YES	NO	
Cancer /Tumors /Radiation	YES	NO	
Tire easily / Weakness	YES	NO	
Back problems	YES	NO	
Psychiatric care	YES	NO	
Depression/Anxiety	YES	NO	
Dry Mouth	YES	NO	
Difficulty Sleeping	YES	NO	
Sleep Apnea	YES	NO	
Currently Not Using Prescribed CPAP	YES	NO	
Snoring	YES	NO	

Pharmacy _____

Phone Number (___) _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for errors or omissions I may have made.

Signature _____Date _____

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DENTAL HISTORY

The more we know about you the better we will be able to serve you.

NAME _____DATE _____

Reason for today s visit _____

_____

Former Dentist _____ Phone Number (_____) _____

Why you left _____ What are you looking for in a dentist _____

_____

Date of last dental cleaning _____ Date of last X-ray _____

What kind of tooth brush do you use? Electric or Manual? (Circle one)

If electric , SONICARE, ORAL-B, or SPINBRUSH? (Circle one)

How often do you brush? Once a day Twice a day Three times a day (Circle one)

How often do you floss? _____

ARE YOU ARE EXPERIENCING ANY OF THE FOLLOWING: PLEASE CIRCLE YES OR NO

Sensitivity to hot, cold, sweet	YES	NO
Biting pain	YES	NO
Sensitivity at the gum line	YES	NO
Bleeding, tenderness, or swelling in your gums	YES	NO
Grinding your teeth or clenching your jaw	YES	NO
Clicking popping jaw joints	YES	NO
Food catching between your teeth	YES	NO
Tired or sore jaw especially in the morning	YES	NO
Bad breath	YES	NO
Mouth sores	YES	NO
Broken tooth	YES	NO
Loose teeth	YES	NO
Missing teeth	YES	NO
Do you hit some teeth before others when you bite	YES	NO
Have you had braces?	YES	NO
Have you had your wisdom teeth removed?	YES	NO
Any complications? _____		
Have you had periodontal / gum treatment before?	YES	NO
Would you like to discuss tooth replacement?	YES	NO
Are you happy with your smile?	YES	NO

If not, which aspects would you change? Shape, color, or contour?_____

Does your dental condition affect:

Decreased self confidence	YES	NO
Diet changes / requirements	YES	NO
Your personal life	YES	NO

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Are you concerned with any of the following:

Snoring affecting your partner's sleep	YES	NO
Old fillings wearing out	YES	NO
Preventing gum disease	YES	NO
Yellowing, discoloring of teeth	YES	NO
Un-natural looking dental work	YES	NO
Discomfort in social situations	YES	NO
Physical discomfort	YES	NO
Your general health	YES	NO
Facial appearance, lip support, premature aging	YES	NO
Shortened teeth from grinding	YES	NO
Loss of chewing function, loss of teeth	YES	NO

Other _____

What can we do to make your dental experience the best?

_____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for errors or omissions I may have made.

Signature _____Date _____