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## Personal History

Date \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Mr./Ms. \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Patient's Last Name First Name Initial

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone(\_\_\_\_\_) \_\_\_\_\_

Cell Phone(\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_ Work Phone(\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse Name \_\_\_\_\_ Employer \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Person Financially Responsible \_\_\_\_\_ Relationship To You \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Person To Contact in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone No.(\_\_\_\_\_) \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Phone No.(\_\_\_\_\_) \_\_\_\_\_

Is your general health good? \_\_\_\_\_ If no, please explain. \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_ Have you been hospitalized in the past two years? \_\_\_\_\_

If yes, please explain. \_\_\_\_\_

Do you bleed excessively when cut? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Are you taking any medications or drugs, including birth control pills? \_\_\_\_\_ If so, please list. \_\_\_\_\_

Have you been advised to premedicate with antibiotics before dental treatment? \_\_\_\_\_

Do you now have, or have you ever had any of the following? If yes, please describe under remarks.

	YES	NO		YES	NO
1. Heart Disease; Angina	<input type="checkbox"/>	<input type="checkbox"/>	13. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Surgery; Bypass, Pacemaker or Prosthetic Valve	<input type="checkbox"/>	<input type="checkbox"/>	14. Radiation Treatment; Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
3. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	15. Hepatitis A _____ B _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Blood Disease; Anemia	<input type="checkbox"/>	<input type="checkbox"/>	16. Liver Disease; Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
5. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	17. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	18. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
7. Mitral Valve Prolapse (MVP)	<input type="checkbox"/>	<input type="checkbox"/>	19. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes			20. Venereal Disease (VD)	<input type="checkbox"/>	<input type="checkbox"/>
(a) Type I	<input type="checkbox"/>	<input type="checkbox"/>	21. Human Immunodeficiency Virus (HIV+)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Type II	<input type="checkbox"/>	<input type="checkbox"/>	22. Allergy to Medications		
9. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	(a) Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
10. Epilepsy; Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	(b) Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
11. Arthritis; Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	(c) Other	<input type="checkbox"/>	<input type="checkbox"/>
12. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	23. Are you, or could you be, pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			24. Other	<input type="checkbox"/>	<input type="checkbox"/>

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Dental History

Reason for today's visit \_\_\_\_\_

When was your last series of x-rays taken? \_\_\_\_\_ Dentist Name/City? \_\_\_\_\_

When was your last cleaning? \_\_\_\_\_ Dentist Name/City? \_\_\_\_\_

Have you ever been instructed in the prevention of tooth decay? \_\_\_\_\_ In caring for your gums? \_\_\_\_\_

Are you happy with the condition/appearance of your mouth/smile? \_\_\_\_\_ Remarks \_\_\_\_\_

Do your gums bleed when you brush/floss? \_\_\_\_\_ Where? \_\_\_\_\_

Does food get caught between any of your teeth? \_\_\_\_\_ Where? \_\_\_\_\_

Do you have sensitive teeth (i.e., to cold, sweets, biting)? \_\_\_\_\_ Where? \_\_\_\_\_

Are you aware of any jaw pain, clicking noise, or headaches in the jaw area? \_\_\_\_\_ Explain. \_\_\_\_\_

Remarks \_\_\_\_\_

## Financial Information

Dental Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. (\_\_\_\_\_) \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ SS# (of insured) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth (of insured) \_\_\_\_\_

Employer's Address \_\_\_\_\_

Have you met your deductible this year? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_ **Please pay deductible today.**

Secondary Dental Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. (\_\_\_\_\_) \_\_\_\_\_ Group No. \_\_\_\_\_

Name of Insured \_\_\_\_\_ SS# (of insured) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth (of insured) \_\_\_\_\_

Employer's Address \_\_\_\_\_

Have you met your deductible this year? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_ **Please pay deductible today.**

Method(s) of payment: Check  Cash  Visa/Mastercard

Consent For Treatment / Guarantee of Payment:

To the best of my knowledge, all the preceding answers are true and correct. I consent to whatever dental radiographs, procedures and anesthetics are necessary for the treatment of the above named patient.

In addition, I guarantee payment to Arbours Aesthetic Dentistry. I authorize my Insurance Company(ies) to pay any and all charges rendered on my behalf, directly to Arbours Aesthetic Dentistry. I authorize the dentist to release any information required for the processing of this claim. I will also be responsible for and will guarantee payment to Arbours Aesthetic Dentistry for any and all charges which will be rejected or not paid for by my Insurance Company(ies). In the event that my account becomes delinquent, I understand I am responsible to pay actual and reasonable collection charges and /or attorney fees. In case of disputes, I agree to resolve matters by arbitration.

Signature \_\_\_\_\_ Date \_\_\_\_\_