Kristy K. Vetter D.D.S.
31371 Niguel Road Suite #F, Laguna Niguel, CA 92677
Phone: (949)248-5205 Website: Drvettersmiles.com
Cell #_____
e-mail_____

Please Complete the following Confidential Information Date_____

Getting to Know You

Patient:_____ Age:_____ Spouse's Name:_____
Last name First name Middle name

If patient is a minor, give parent's or guardian's name:_____Relationship:_____

Mailing Address:_____

☐Married ☐Single ☐Divorced ☐Separated ☐Widowed Residential Phone: (___)_____

Driver's License #:_____ Social Security #:_____ Birthdate:_____

Employer:_____ Occupation:_____ Date Employed:_____

Business address:_____Business phone:_____

Spouse Employed By:_____Occupation:_____Date Employed:_____

Spouse's S.S.#:_____ Spouse's Birthdate:_____

Name of Nearest Relative not living with you_____ Relationship:_____

Complete Address:_____Phone:(___)_____

How did you hear about our office?_____
Who can we thank for referring you?_____
Is another member of your family or relative a patient at our office?_____
If so who?_____
Person to contact in case of emergency:_____
Relationship:_____ Phone number: ( ) _____
Address:_____

Preference of Payment

☐ Cash on day of treatment ☐ Visa #_____
☐ Check ☐ Dental Fee Plan (Dental Credit Card)
☐ MasterCard #_____ ☐ Other

Person Responsible for this Account:_____
Address:_____Phone:_____

INSURANCE

Primary Carrier:
Insurance Co:_____
Employee:_____
Union or Local #_____
Group #_____
Date Employed:_____
S.S.#_____

Secondary Carrier:
Insurance Co._____
Employee:_____
Union or local #_____
Date Employed:_____
S.S.#_____

Terms and Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all services are charged directly to the patient, and that he or she is personally responsible for payment of all dental services not paid by the insurance company. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 90 days. I agree to pay the reasonable value of all dental services rendered by the doctor in this office.

Consent for Treatment

I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this health history form to administer any dental treatment deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all the possibilities complications of the procedures, anesthetics and/or drugs.

Signed_____ Date_____
Relationship to patient_____

Patient Name_____ HEALTH QUESTIONAIRE

MEDICAL HISTORY

1. Are you in good health? yes no Date of Last Physical Examination?_____
2. Are you now under the care of a physician? If so, why?_____ yes no
3. Physicians name and address:_____
4. Have you ever had a serious illness or operation? If so, what?_____ yes no
5. Have you ever been hospitalized? If so why?_____ yes no
6. Do you have chest pain upon exertion?_____ yes no
7. Are you ever short of breath upon mild exercise?_____ yes no
8. Have you ever taken Fosamax or any other Bisphosphonate?_____ yes no
9. Are you taking blood thinners / Coumadin_____ yes no
10. Do you wear a cardiac pacemaker?_____ yes no
11. Have you ever had heart surgery?_____ yes no
12. Have you had a joint replacement?, If yes what?_____ yes no
13. Are you taking any drugs or medications?_____ yes no
    List Medications and reason for taking them:_____
    _____
14. Are you allergic or have you reacted adversely to any of the following : (Circle Y for Yes and N for No)

Y N Penicillin	Y N Sulfa Drugs	Y N Percodan	Y N Local Anesthetic	Y N Latex
Y N Tetracycline	Y N Aspirin	Y N Valium	Y N Novacaine	Y N Other_____
Y N Erythromycin	Y N Codeine	Y N Nitrous Oxide	Y N Xylocaine	_____

15. Have you ever had any of the following: (Circle Y for Yes and N for No)

Y N Anemia	Y N Thyroid Disease	Y N Radiation Treatment	Y N Pain in jaw joints
Y N Heart Murmur	Y N Bleeding Problems	Y N Allergies	Y N HIV positive
Y N Heart Failure	Y N Hemophilia	Y N Hives or Skin Rash	Y N Epilepsy
Y N Heart Disease	Y N Bruise Easily	Y N Asthma or Hay Fever	Y N Mental Disorders
Y N Heart Attack	Y N Rheumatic Fever	Y N Fainting or Seizures	Y N Psychiatric Care
Y N Angina Pectoris	Y N Scarlet Fever	Y N Artificial Joint	Y N Stroke
Y N Mitrovalve Prolapse	Y N Blood Diseases	Y N Arthritis/Rheumatism	Y N Glaucoma
Y N Artificial Heart Valve	Y N Hepatitis A (Infectious)	Y N Head Injuries	Y N Herpes
Y N Congenital Heart Disease	Y N Hepatitis B (Serum)	Y N Stomach Ulcers	Y N Cold Sores
Y N High Blood Pressure	Y N Jaundice/Liver Disease	Y N Difficulty in Swallowing	Y N Sinus Trouble
Y N Respiratory Disease	Y N Kidney Disease	Y N Venereal Disease	Y N Ankle Swelling
Y N Tuberculosis	Y N Tumors or Growths	Y N Drug Addiction	Y N Other_____
Y N Nervous Disorder	Y N Cancer	Y N Blood Transfusion	_____
Y N Diabetes	Y N Chemotherapy	Y N AIDS (Acquired Immune Deficiency Syndrome)	

16. Do you smoke, chew tobacco, or use any tobacco product? If yes, what and how much_____ yes no
17. Do you use any alcohol products? If yes, how much?_____ yes no
18. (Women) Are you pregnant? If yes, how many months?_____ yes no 19.
(Women) Are you taking birth control? If so, what?_____ yes no
20. Have you ever taken an antibiotic or has your M.D. ever told you to take an antibiotic for dental care? yes no

DENTAL HISTORY

1. Please describe the reason for your appointment today:_____
2. Are you in discomfort at this time?_____ yes no
3. Have you ever had a serious problem associated with previous dental treatment?_____ yes no
   If yes, please explain:_____
4. Do you have, or have you had any of the following? (circle Y for Yes or N for No)

Y N Pain in jaw (TMJ)	Y N Bleeding sore gums	Y N Orthodontics (braces)	Y N Sensitive to hot
Y N Clicking / popping jaw	Y N Burning tongue / lips	Y N Loose teeth	Y N Sensitive to cold
Y N Difficulty opening jaw	Y N Bad taste / breath	Y N Clenching or grinding	Y N Sensitive to sweet
Y N Difficulty closing jaw	Y N Blisters on lips or mouth	Y N Periodontal (gum) disease	Y N Sensitive to biting

5. Does dental treatment make you nervous? No Slightly Moderately Extremely
6. How do you routinely care for your teeth? Brush Floss Water-Pik Fluoride rinse/gel Other
7. How long has it been since your last full mouth x-rays?_____
8. Previous Dentist:_____ Date of last visit:_____
   Phone number:_____ City, State:_____
9. Are you happy with your smile?_____ yes no
10. Would you like your teeth to be whiter?_____ yes no

_____ _____

Signature of Patient Date Signature of Dentist Date