Isaacs Dental
Digital Endo & Implant Surgery

Call 510-796-8400
www.drisaacsdental.com

PATIENT INFORMATION

Patient's Name _____ Age _____ Date of Birth _____ Soc. Sec. No. _____

If Child, Name of Parent _____

If Full-time Student, Name of School _____ Year in School _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Patient (or Parent) Employed by _____ How long? _____ Bus. Phone _____

Spouse Employed by _____ How long? _____ Bus. Phone _____

Your Children's Names and Ages _____

In Case of Emergency, Name of Nearest Relative Not Living With You _____ Relationship _____

Complete Address _____ Phone _____

Name of Person Who Will Be Responsible for This Account _____

Who Referred You to Our Office? _____

INSURANCE ONLY

Name of Insurance Plan _____ Group No. _____

Name of Policyholder/Employee _____ Soc. Sec. No. _____

Is There a Deductible? _____ Amount of Deductible _____ How Much Has Been Paid? _____

If Dual Coverage, Name of Other Dental Plan _____ Group No. _____

Name of Policyholder/Employee _____ Soc. Sec. No. _____

MEDICAL HISTORY

Physician's Name _____ Address _____

Are You in Good Health? _____ If No, Explain _____

Are You Now, or Have you Been Under a Physician's Care During The Past Two Years? _____

Have You Been Hospitalized or Had a Serious Illness in the Past Five Years? _____

Are You Taking Any Drugs or Medicines Now? _____ If So, Give Names and Purpose_____

_____

Are You Allergic to Penicillin or Any Other Drugs? _____

ARE YOU TAKING BISPHOSPHONATES? ex: Fosamax, Actonel, Boniva, Aredia, Zometa

Women: Are You Pregnant? _____ If So, How Long? _____

Circle Any of the Following You Have, Now, or Have Ever Had:

Rheumatic Fever	**High Blood Pressure**	**Diabetes**	**Liver Disease or Hepatitis**
Congenital Heart Lesions	**Abnormal Bleeding**	**Tuberculosis**	**Kidney Disease or Jaundice**
Heart Murmur	**Blood Disease or Anemia**	**Emphysema**	**Stomach, Intestinal Disorders**
Heart Disease	**Epilepsy**	**Sinus Trouble, Asthma**	**Venereal Disease**
Stroke	**Thyroid Condition**	**Tumors or Growths**	**Fainting, Nervousness**

DENTAL HISTORY

How Long Since Your Last Dental Visit? _____ What Was Done Then? _____

Name of Previous Dentist _____ City _____

Purpose of This Visit: Check Up? _____ Other Dental Problem (Describe) _____

Have You Ever Had Unusual Difficulties or Complications During or After Dental Treatment? _____

Circle Any of the Following You Have Now, or Have Ever Had:

Bleeding Gums Extreme Sensitivity	**Extreme Sensitivity**	**Orthodontic (Straightening) Treatment**
Food Collects Between Teeth	**Grinding, Clenching Habit**	**Periodontal (Gum) Treatment**
Painful Jaw Joint	**Long lasting Mouth Sores**	**Endodontic (Root Canal) Treatment**
Loose Teeth	**Complicated Extractions**	**Crown (Cap) or Bridge Treatment**
		Denture Treatment

Is There Anything Else the Doctor Should Know Before Beginning Dental Treatment? _____

I hereby give consent for necessary dental treatment _____Date_____