Wayne T. Yee, DDS, MAGD
John F. Field, DDS Ajay Patel, DDS
3125 Coffee Road Suite 1
Modesto, CA 95355

Today's Date: _____

PATIENT INFORMATION

Name: _____Birthdate:_____Age:_____
Address: _____
Home Phone #: _____Cell Phone #_____
Work Phone #: _____May we call you there? Y/N Best # to reach you: H/C/W Marital Status: _____
Whom may we thank for referring you to our office? _____
Employer: _____Occupation: _____
Please list any changes in your employer group/dental insurance coverage. ***If none, skip to Health History***.
Subscriber Name: _____DOB: _____
Subscriber Employer: _____SS#/Ins. ID#: _____
Insurance Co.: _____Ins. Co. Phone #: _____
Relation to Patient: _____Group #: _____
Secondary Insurance_____ Ins. Co. Phone #:_____
Insurance Co.: _____Ins. Co. Phone #: _____
Physician: _____Physician's Phone #: _____
Emergency Contact: _____Phone #: _____
E-mail _____

HEALTH HISTORY

Have you been told you snore, stop breathing while you sleep, or told you have sleep apnea? Y/N Do you wear a CPAP? Y/N

Do you have/have you had any of the following?

Alzheimer's Disease……....Y/N
Artificial Heart Valve(s)……...Y/N
Artificial Joint(s) When? _____ ……...Y/N
Asthma…….....Y/N
Cancer/Malignancies…….....Y/N
Diabetes ……...Y/N
Dizziness……...Y/N
Dry Mouth……Y/N
Eating Disorder…… Y/N
Epilepsy/Seizures……..Y/N
HIV+……Y/N
Heart Attack……..Y/N
Heart Murmur……...Y/N
Hemophilia/Blood Disorder…….....Y/N
High Blood Pressure……Y/N
Pacemaker When? _____.....Y/N
Rheumatic Fever When? _____ ……Y/N
Sinus Congestion/Allergies……..…Y/N
Stroke When? _____ ……...Y/N
Tuberculosis When? _____ ……...Y/N

Are you allergic to any of the following?

Aspirin……Y/N
Codeine……Y/N
Dental Anesthetics……...Y/N
Latex……Y/N
Metals …….... Y/N
Penicillin…… Y/N
Sulfa Drugs…… Y/N
Other: _____ .....Y/N
Have you had gum surgery?.....Y/N
Do you take recreational drugs?.....Y/N
Do you consume alcohol?.....Y/N
Do you smoke/use tobacco?.....Y/N

Are you taking blood thinners?.....Y/N
Are you taking or have taken Fosamax (Bisphosphonates)?.....Y/N
Ladies: Are you pregnant?.....Y/N
If yes, how far along? _____

Have you ever been told you need to take a pre-med antibiotic prior to dental treatment? _____
Please list ***ALL*** medications you are currently taking, prescribed ***AND*** over-the-counter: _____
_____

I give Drs. Yee, Field, Patel and their staff permission to discuss my treatment with the following people (spouse, children, care-taker):
Name(s): _____Signed: _____

I consent to dental treatment (procedures, anesthetics, medications, etc.) considered necessary or advisable by my treating Doctor (Yee, Field, Patel). I agree to pay for services rendered by this practice. I have seen a copy of the **Dental Materials Fact Sheet and the Notice of Privacy Practices** and I have had my questions answered regarding it.

Patient Signature: _____Doctor Initial: _____

IF YOU HAVE FAMILY OR FRIENDS WHO NEED A DENTAL HOME, ASK US ABOUT OUR SMILE CARDS