Paul Taylor DMD
Advanced Dentistry

3737 Moraga Ave #B307
San Diego, CA 92117
(858) 273-1631

4320 Genesee Ave #101
San Diego, CA 92117
(858) 277-8100

Welcome! Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient Information

Date: ____/____/____

Patient's Last Name: _____

First Name _____ MI ____

SS/HIC/Patient ID#: _____

Address: _____

City _____

State_____ Zip _____

E-mail _____

Sex: ☐ M ☐ F Age:_____

Birth date: _____

Occupation_____

Patient Employer/School _____

Employer/School Phone ( ) _____

Employer/School Address _____

☐ Married ☐ Widowed ☐ Single
☐ Minor ☐ Separated ☐ Divorced
☐ Partnered for _____ Years

Spouse's Name _____

Birth date_____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account?

_____

Relationship to patient_____

Insurance Co._____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's name_____

Birth Date _____

SS# _____

Relationship to Patient _____

Insurance Co._____

Group # _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with:_____
_____Name of Insurance Company(ies) and assign directly to
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date

Relationship to Patient

Phone Numbers

Home _____ Cell Phone _____

Work _____ Ext. _____ Spouse's Work _____

IN CASE OF EMERGENCY, CONTACT
(Specifically someone who does not live in your household)

Name _____ Home Phone _____

Relationship _____ Work Phone _____

Dental History

Reason for today's visit _____ Date of last dental visit _____

_____ Date of last dental X-rays _____

Former Dentist _____ How often do you floss? _____

City/State _____ How often do you brush? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

☐ Yes	☐ No	Bad breath	☐ Yes	☐ No	Jaw pain or tiredness
☐ Yes	☐ No	Bleeding gums	☐ Yes	☐ No	Lip or cheek biting
☐ Yes	☐ No	Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings
☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing
☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing
☐ Yes	☐ No	Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Orthodontic treatment
☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No	Pain around ear
☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Periodontal treatment
☐ Yes	☐ No	Fingernail Biting	☐ Yes	☐ No	Sensitivity to cold
☐ Yes	☐ No	Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat
☐ Yes	☐ No	Foreign objects	☐ Yes	☐ No	Sensitivity to sweets
☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Sensitivity when biting
☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth

Health History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phenetermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

☐ Yes	☐ No	AIDS/HIV	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery
☐ Yes	☐ No	Anemia			
☐ Yes	☐ No	Arthritis, Rheumatism	☐ Yes	☐ No	Blood Disease
☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No	Chemical Dependency
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Chemotherapy
☐ Yes	☐ No	Back Problems	☐ Yes	☐ No	Circulatory Problems

Health History (continued)

☐ Yes ☐ No Congenial Heart Lesions
☐ Yes ☐ No Cortisone Treatments
☐ Yes ☐ No Cough, persistent or bloody
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting or dizziness
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Headaches
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Problems
☐ Yes ☐ No Hepatitis Type _____
☐ Yes ☐ No Herpes
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Jaw Pain
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Nervous Problems
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Respiratory Disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Special Diet
☐ Yes ☐ No Stroke
☐ Yes ☐ No Swollen Feet or Ankles
☐ Yes ☐ No Swollen Neck Glands
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Tumor or growth on head or neck
☐ Yes ☐ No Ulcer
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Weight Loss, Unexplained
☐ Yes ☐ No Do you wear contact lenses?

Women:

☐ Yes ☐ No Are you pregnant?
Due date _____
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No Taking birth control pills

Medications

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____

Pharmacy Name _____
Phone _____

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other
_____
_____

Updates (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No
For what conditions? _____
Are you taking any new medications? ☐ Yes ☐ No
If so, what? _____
Patient's Signature _____
Date _____
Doctor's Signature _____
Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No
For what conditions? _____
Are you taking any new medications? ☐ Yes ☐ No
If so, what? _____
Patient's Signature _____
Date _____
Doctor's Signature _____
Date _____