

MEDICAL ALERTS

NICHOLAS M. GISTARO
FAMILY DENTIST

Welcome to our Office

549 "H" Street, Suite A
Chula Vista, CA 91910

ACCT.# _____

Date _____

PATIENT INFORMATION

Patient Name _____ SS# _____
Last Name First Name

Address _____ Drivers Lic. # _____

City _____ State _____ Zip _____ Home Phone _____

E-Mail _____ Cell Phone _____

Sex M F Birthdate _____ Age _____ Marital Status _____

Patient Employed By _____ Occupation _____

Are you a full/part time student? Yes No Where? _____

Business Address _____ Work Phone _____

Have any of your family members been into our office? _____

How were you referred? Patient referral Who may we thank? _____

Telephone Book Saw Bldg./Sign Internet (Which Site?) _____

1-800 Dentist Dr. Referral _____ Other _____

In Case of Emergency, who should be notified? _____

Relationship _____ Address _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Responsible Person Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____

Business Address _____ Bus. Phone _____

Insurance Company _____ Insurance Phone _____

Group # _____ SS# _____ ID# _____

SECONDARY INSURANCE

Is patient covered by additional insurance _____ Yes No

Subscriber Name _____ Relationship to Patient _____ Birthdate _____

Address (if different from patient's) _____ SS# _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Bus. Phone _____

Insurance Company _____ Insurance Phone _____

Group # _____ SS# _____ ID # _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Phone _____

Date of last dental care _____ Date of last dental x-rays _____

Check () if you have had problems with any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot or cold |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growth in mouth | <input type="checkbox"/> Sensitivity when biting |

Do you wear dentures or partial dentures? _____ If so, when were they made? _____

Is there any other information we should know about any other dental visits? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illness or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? _____ if yes, give dates _____

(women) Are you pregnant? Yes No Taking Birth Control Pills? Yes No

Check () if you have or have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cough (persistent) | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |

MEDICATIONS

List Medications you are currently taking _____

Bone Loss Medication _____

Pharmacy Name _____ Phone _____

ALLERGIES

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

Doctor's Notes _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____

Signature _____