DEL MAR FAMILY DENTISTRY
DALE R. TRUDEAU, D.D.S.
THOMAS A. FITZPATRICK, D.D.S.

CONFIDENTAL PATIENT HISTORY

Today's Date: _______/_______/_________

Name: ____ Prefer to be called: __________________

Complete Mailing Address: ____ Zip__________

Employer/Address:____

Birth Date: _______/________/_________ Home:_____________________

Social Security #:_______________________ Work:_____________________

Email address: ________________________ Cell:_____________________

Whom may we thank for referring you?________________________________

INSURANCE INFORMATION

Responsible Party/Spouse information: (fill out if patient is a minor or spouse insurance is involved)

Name: ______________________________Employer/Address:___________________________

Relationship to patient: _______________ DOB: ____/____/______ SS#:____________________

Cell Phone:____________________

If a full-time student, name of School/Grade/State:_______________________________________

Do you now have, or have you ever had any of the following? Please check all that apply.

☐Heart Disease/Surgery	☐Emphysema
☐Artificial Valve	☐Asthma
☐Heart Attack/Failure	☐Eating Disorder
☐Artificial Joint	☐Frequent Cough
☐Abnormal Blood Pressure	☐Cold Sores/Fever Blisters
☐Stroke	☐Epilepsy/Seizures
☐Blood Clotting Disorder	☐Fainting/Dizziness
☐Cancer/Radiation/Chemo	☐Pacemaker
☐Traumatic Accident	☐Headaches
☐Arthritis/Sore Joints	☐GERD/Acid Reflux
☐HIV Positive, ARC or AIDS	☐Sleep Apnea
☐Hepatitis Type: _________	☐Diabetes
☐Chemical Dependency	☐Tuberculosis

Have you ever had any other serious illness not listed above? ______________________________

Are you allergic to any drugs, medication, or latex rubber? Please list: ____________________________

Physician name and phone: _______________________________Phone: ________________________

Emergency contact Name: _____________________Phone_______________Relation_____________

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Dental History

Primary Reason for your visit:_______________________________________

Date of last dental visit: ____/____/____

Have you ever been instructed to take antibiotics before any dental or surgical procedure? ☐Yes ☐ No

Are you currently taking **any drugs or medication**? ☐Yes ☐No

Please list the medication and purpose:____

Have you been hospitalized or undergone any major surgery in the past five years?☐Yes ☐No

If so, please provide details and dates:____

Women: Do any of the following apply?☐ Pregnant (Due Date____/_______) ☐Trying to conceive ☐Nursing

Have you ever had any serious problems associated with previous dental treatment?☐Yes ☐No

If so, please explain. ____

Have you ever been diagnosed or treated for periodontal (gum) disease? ☐Yes ☐ No

Have you been concerned about bad breath, unpleasant odor or taste in your mouth?☐ Yes ☐ No

Do you feel sensitivity with any of your teeth when brushing or flossing?☐Yes ☐No

Are there any swellings, growths, inflamed areas, or unhealed injuries in your mouth?☐Yes ☐ No

Does food catch between your teeth? If so, where:____

Is any part of your mouth sensitive to temperatures, biting pressure, sweets?☐ Yes ☐No

When was your last cavity/restoration?____

Do you have a history of dry mouth?☐Yes ☐No

How many times per day do you consume candy, breath mints, soda, sports drinks, or other sweets?☐**0-1**☐**1-2**☐**2+**

Have you had orthodontic treatment or bite adjustments? ☐Yes ☐No

Do you have unreplaced missing teeth? ☐Yes ☐No

If so, have you chosen not to replace them?____

Have you noticed any movement, shifting, or change in your teeth?☐Yes ☐No

Have you had locking or clicking in your jaw, inability to open wide or chew tough foods?☐Yes ☐No

Do you awaken with the awareness of your teeth and jaws? ☐Yes ☐No

Do you clench and/or grind your teeth during the day or night?☐Yes ☐No

Is there anything you would like to change about the appearance of your smile? ____________________________________

Do you have any pain around your eyes, ears, nose, neck or mouth? ☐Yes ☐ No

If so, where and how often?____

How often do you get headaches? ______________________________Neck aches?__________________________________

Do you snore?☐Yes ☐No

Do you wake up frequently or have trouble falling asleep?☐Yes ☐No

Do you have a history of extensive dental treatment?☐Yes ☐No

Has it been due to: ☐ New cavities ☐gum disease ☐replacement of dental work

Do you want to keep your remaining teeth?☐Yes ☐No

Please add anything you feel is important:____

Authorization

I understand that I am responsible for all costs of dental treatment. Payment is due at the time of services. If I do not pay the entire new balance within 25 days of monthly billing date, a service charge (1.5% per month, 18% annually) will be added to the account. The information on this page and the dental/medical histories are correct to the best of my knowledge. I hereby authorize the Dental Office to administer such medications and perform such diagnosis and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment of insurance benefits to be made directly to the Dental Office otherwise payable to me. A copy of the dental materials fact sheets and the office's privacy policies have been made available to me. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party and/or other health professionals. I understand that if I am unable to keep this appointment, I will give a minimum of 48 hours' notice or I will be responsible for the charge for time reserved. A $10 fee has been added to each appointment due to elevated PPE cost during the ongoing pandemic.

Signature: ____Date: __________________________