

**Please complete our confidential patient registration forms with your keyboard and mouse. Please print, sign, and then mail, fax, or bring the forms with you to your next appointment. Our mailing address is Robert L Simon, DDS, 1321 N. Harbor Blvd. Suite 203 Fullerton, CA 92835 Our fax number is : (714) 525-5998**

PATIENT INFORMATION

Referred by:  A friend \_\_\_\_\_  Dr. \_\_\_\_\_  
 Yellow pages  Something in the mail  Dental society  Other (please describe)

\_\_\_\_\_  
Patient's name (Mr. Dr. Mrs. Ms.) \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Best appointment times: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's license: \_\_\_\_\_

INSURANCE INFORMATION

Primary carrier: \_\_\_\_\_ Group # \_\_\_\_\_

Claims sent to: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employee name: \_\_\_\_\_ Social Security: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Secondary carrier: \_\_\_\_\_ Group # \_\_\_\_\_

Claims sent to: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employee name: \_\_\_\_\_ Social Security: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Date of birth: \_\_\_\_\_

HEALTH QUESTIONNAIRE

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

WHAT IS YOUR DENTAL PROBLEM \_\_\_\_\_

LAST DENTIST YOU SAW Dr. \_\_\_\_\_ City \_\_\_\_\_

DATE OF LAST PROFESSIONAL CLEANING \_\_\_\_\_

WHAT MEDICATIONS DO YOU TAKE DAILY?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S NAME Dr. \_\_\_\_\_ City \_\_\_\_\_

Yes  No Are you having pain or discomfort at this time?

Yes  No Have you been a patient in a hospital in the past year?

Yes  No Have you ever taken Phen-fen?

Yes  No Have you been under the care of a physician in the past year?

For what condition? \_\_\_\_\_

Yes  No Are you allergic or made sick by any drugs or medications?

latex

penicillin

sulfa

Other \_\_\_\_\_

Yes  No Have you ever had any excessive bleeding requiring special treatment?

Yes  No When you walk up stairs do you ever have chest pain?

Yes  No Do your ankles swell during the day?

Yes  No Have you lost or gained more than 10 pounds in the last year?  
(if yes, check one)

Yes  No Are you on a special diet?

Yes  No Has a medical doctor ever said you have cancer or a tumor?

Yes  No WOMEN: Are you pregnant? Due date \_\_\_\_\_

HEALTH QUESTIONNAIRE

HAVE YOU HAD ANY OF THE FOLLOWING:

- |   |   |   |                                    |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Hay fever        | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Liver disease    | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Chronic cough    | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Angina    |
| <input type="checkbox"/> Sinus trouble          | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Hemophilia       | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> Blood transfusion      | <input type="checkbox"/> Hives            | <input type="checkbox"/> Thyroid disease  | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Drug dependence        | <input type="checkbox"/> Cold sores       | <input type="checkbox"/> Chemotherapy     | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Fainting  |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pain in jaws     | <input type="checkbox"/> Dizzy spells     | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Heart pacemaker        | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Bruise easily    | <input type="checkbox"/> HIV       |
| <input type="checkbox"/> Heart surgery          | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Anemia           |                                    |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Kidney trouble   |                                    |
| <input type="checkbox"/> Mental retardation     | <input type="checkbox"/> Cerebral palsy   |   |                                    |

ANY DISEASE, CONDITION OR PROBLEM WE SHOULD KNOW ABOUT BUT NOT MENTIONED ABOVE? \_\_\_\_\_

To the best of my knowledge, all the preceding answers are true. If there is a change in your health or medications please inform this office.

SIGNATURE of Patient \_\_\_\_\_ Reviewed by \_\_\_\_\_  
(parent or guardian)

On dates following the initial visit:

Date \_\_\_\_\_  Yes  No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?  
\_\_\_\_\_

Date \_\_\_\_\_  Yes  No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?  
\_\_\_\_\_

Date \_\_\_\_\_  Yes  No There have been changes in my health and/or the drugs I take since the last visit. If yes, what are the changes?  
\_\_\_\_\_