82204 Hwy 111 Suite A
Indio, CA 92201
(760) 775-5552

50249 Cesar Chavez St Suite G
Coachella, CA 92236
(760) 398-9848

30877 Date Palm Dr. Suite B4
Cathedral City CA 92234
(760) 202-7400

31500 Grape St Suite 8
Lake Elsinore CA 92532
(951)471-2834

Information Update

Please review and update the following information:

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ - _____ (Zip Code)

Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance phone number _____

Subscriber ID# _____

Group # _____

Medical Update

Name and phone number of your physician:

_____

_____

Name and phone number of your preferred pharmacy:

_____

_____

Indicate which of the following conditions are active or current.

By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Ativan
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Antibiotics
- [ ] Anxiety
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Autism
- [ ] Blood Disease
- [ ] Cancer
- [ ] Cholesterol
- [ ] Codeine
- [ ] Cong Heart Failure
- [ ] Diabetes
- [ ] Dialysis
- [ ] Dizziness
- [ ] Embolia
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Valve Implant
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Hyper thyroid
- [ ] Hypo Thyroid
- [ ] Ibuprofen
- [ ] iodine
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lupus
- [ ] Menopenem
- [ ] Mental Disorders
- [ ] mercury
- [ ] Metal Implants
- [ ] Motrin
- [ ] Naproxen
- [ ] Nervous Disorders
- [ ] Open Heart Surgery
- [ ] Other
- [ ] Pacemaker
- [ ] PCN
- [ ] Penicillin
- [ ] Pneumonia
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizures
- [ ] Shunt
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Tylenol
- [ ] Ulcers
- [ ] Venereal Disease

- [ ] Recent Hospitalization
- [ ] FEMALE: Currently Pregnant/Possibly Pregnant
- [ ] Recreational Drugs
- [ ] FEMALE: Taking Birth Control Pills
- [ ] Tobacco/Vape Use
- [ ] FEMALE: Nursing
- [ ] Alcohol Use

If any conditions or alerts selected above need further clarification, please describe:

Have you ever been instructed to take antibiotic premedication for your dental visits? If yes, please explain: * ◯ Yes ◯ No

Pre Med:

Describe any current or past medical treatment or impending surgery.

Are you currently taking or have you ever taken bone denisty medication (Bisphosphonates) such as Boniva, Fosamax, Didronel, Zometa, Actonel, etc? If yes, please describe below

◯ Yes ◯ No

Bisphosphonate:

Are you currently taking any blood thinner medication including daily doses of aspirin? ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Provider notes

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Response Date: _____