Dr. Ritu Bhardwaj, DDS
620 E. Alvin Dr. #E
Salinas, CA 93906
(831) 449-8363

North Salinas DENTAL

Our goal is to help you achieve and maintain your maximum oral health, a smile you are proud to show off. The better we communicate, the better we are able to care for you and together achieve this goal. Please fill out this form as completely as possible. We want to make sure we are well informed about your medical history, dental history, and any other factors that might affect your dental health and treatment.

ABOUT YOU

How did you hear about us? _____
Name (First, Middle, Last): _____
Preferred Name: _____ Gender: ☐ Male ☐ Female _____
Birthdate: _____ Age: _____ SS#: _____
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor
Address: _____
City: _____ State: _____ Zip: _____
☐ Home Phone: _____ Cellphone: _____
Email address: _____ Ok to email? ☐ Yes ☐ No
Best time of the day to reach you: _____
Employer: _____ Occupation: _____
Emergency Contact (specify someone who does not live in your household):
Name: _____ Relationship: _____
Emergency Contact Phone Number: _____

DENTAL INSURANCE

Person Responsible for Account: _____
Do you have dental insurance coverage? ☐ Yes ☐ No

Primary Insurance

Insurance Subscriber's Name: _____
Subscriber's Birthdate: _____ SS#: _____
Dental Insurance Co. name & phone: _____
Subscriber ID #: _____ Group#: _____
Employer: _____ Occupation: _____
Subscriber's phone#: _____ Relationship: _____

Do you have a Secondary Insurance? ☐ Yes ☐ No
Insurance Subscriber's Name: _____
Subscriber's Birthdate: _____ SS#: _____
Dental Insurance Co. name & phone: _____
Subscriber ID #: _____ Group#: _____
Employer: _____ Occupation: _____
Subscriber's phone#: _____ Relationship: _____

DENTAL HISTORY

Why have you come to our office today? _____
Are you in pain? ☐ Yes ☐ No _____ If yes, for how long? _____
Previous Dentist: _____ Phone: _____
Last dentist visit: _____
What was done? _____ Date of Last Cleaning: _____
Date of last X-rays: _____
Have you ever been told that you require antibiotics before dental treatment? ☐ Yes ☐ No

Do you have or have you ever had any of the following conditions? Circle "Yes" or "No"

Bad Breath Yes No	Food Stuck Between Teeth Yes No	Pain Around Ear Yes No
Bleeding Gums Yes No	Pain When Brushing Yes No	Clenching or Grinding Teeth Yes No
Broken Fillings/Teeth Yes No	Swollen or Painful Gums Yes No	Sensitivity to Cold/Hot/Sweet Yes No
Sores or Growths in Mouth Yes No	Jaw Pain Yes No	Chew on Only One Side Yes No
Lip or Cheek Biting Yes No	Clicking or Popping of Jaw Yes No	Loose Teeth Yes No
Snoring Yes No	Dry Mouth Yes No	Braces Yes No

Have you ever had a difficult problem/bad experience with any previous dental work? ☐ Yes ☐ No
If yes, please explain: _____

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How would you classify your current dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor
On a scale of 1-10, how would you rate your smile (10 being the best)? _____
Would you like whiter teeth? ☐ Yes ☐ No Would you like straighter teeth? ☐ Yes ☐ No
How many times a day do you brush/floss? _____ / _____ Bristle type: ☐ Soft ☐ Medium ☐ Hard

HEALTH HISTORY

Are you currently under the care/supervision of a physician? ☐ Yes ☐ No
If yes, please explain why: _____
_____
Physician's Name: _____ Phone: _____
Are you currently taking any prescription medications? ☐ Yes ☐ No
If yes, please list medications with correlating diagnosis: _____
_____

Are you currently taking any oral contraceptives (WOMEN ONLY)? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following? (circle all that apply):
Penicillin Clindamycin Ibuprofen/Motrin Aspirin Vicodin Percocet Codeine Latex Barbiturates/Sleeping Pills
Dental Anesthetics (ex. Lidocaine) Augmentin Erythromycin Tetracycline Jewelry/Metals Sulfa
Please list any other allergies: _____
_____

Have you ever had any of the following medical conditions? Circle "Yes" or "No"

Abnormal Bleeding Yes No	Fainting Spells Yes No	Mitral Valve Prolapse Yes No
Alcohol or Drug Abuse Yes No	Frequent Headaches Yes No	Pacemaker Yes No
Anemia Yes No	Glaucoma Yes No	Psychiatric Care Yes No
Arthritis Yes No	Hay Fever Yes No	Radiation Treatment Yes No
Artificial Joints/Heart Valves Yes No	Heart Attack Yes No	Rheumatic/Scarlet Fever Yes No
Asthma Yes No	Heart Murmur Yes No	Seizures Yes No
Blood Transfusion Yes No	Heart Surgery Yes No	Shingles Yes No
Cancer/Chemotherapy Yes No	Hemophilia Yes No	Sickle Cell Disease/Trait Yes No
Colitis Yes No	Hepatitis Yes No	Sinus Problems Yes No
Congenital Heart Disease Yes No	Herpes/Fever Blisters Yes No	Stroke Yes No
Diabetes Yes No	High/Low Blood Pressure Yes No	Tobacco Dependency Yes No
Difficulty Breathing Yes No	HIV or AIDS Yes No	Thyroid Problems Yes No
Emphysema Yes No	Kidney Problems Yes No	Tuberculosis Yes No
Epilepsy Yes No	Liver Disease Yes No	Venereal Disease Yes No

Please explain any serious medical conditions you have ever had: _____
_____

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that is my responsibility to inform this office of any changes in my insurance or medical status. I understand that I am required to pay for any dental services provided. I hereby authorize payment directly to this doctor otherwise payable to me, in the situation where my insurance plan does not pay for a portion or a procedure, I acknowledge that I am responsible to pay in full for that procedure. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_____ _____ _____ _____
Patient's Signature (Parent or Guardian) Date Reviewing Dentist's Signature Date