Allen Ontiveros, DDS
24953 Paseo De Valencia
Suite 11-C
Laguna Hills, CA 92653
Ph # : 949-643-2803
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[redacted]

Patient Personal Information

Title ____ Nickname ____ Birth Date ____ Age ____
Last, First ____ ____ ____ Marital Status ____ Sex ____
Address ____ Home # ____ Work # ____
____ Cell # ____ Drive Lic ____
City, State, Zip ____ Emergency Contact ____ Emergency Phone # ____
Email ____ Student ____ SSN ____
Health Care Guardian Name ____ School Name ____
Health Care Guardian Phone # ____ Referral Type ____

Person responsible/guarantor for paying bills

Title ____ Nickname ____ Birth Date ____ Age ____
Last, First ____ Marital Status ____ Sex ____
Address ____ Home # ____ Work # ____
____ Cell # ____ Drive Lic ____
City, State, Zip ____ SSN ____
Email ____

Do you have Primary Dental Insurance? __ Yes __ No

Group No/Name ____
Insurance Name ____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____ ____
Relationship to Patient ____ Birth Date ____
Subscriber ID ____

Do you have Secondary Dental Insurance? __ Yes __ No

Group No/Name ____
Insurance Name ____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____
Relationship to Patient ____ Birth Date ____
Subscriber ID ____

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis

☐ Y ☐ N No Change Since Last Recorded
☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Color Blindness
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Joint Replacement
☐ Y ☐ N Kidney
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Pacemaker
☐ Y ☐ N Unusual Weight Loss
☐ Y ☐ N Urinate Frequently

Other

☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Does food catch between your teeth ? _____

Do you want to learn to control your dental disease and retain your teeth ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? _____

Do you smoke ? _____

Women Only

Are you pregnant? _____

If Yes, what is your due date ? _____

Are you currently nursing ? _____

Do you have menstrual period problems ? _____

Are you on hormone replacement therapy ? _____

Are you on birth control pills / fertility drugs ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**