BALFOUR DENTAL

CENTER FOR COMPLETE DENTISTRY

100 Cortona Way, Suite 100
Brentwood, CA 94513

www.balfourdental.com

Ph: (925)634-9901
Fax: (925)634-1352

PATIENT INFORMATION

Patient Name: _____ Male _____ Female _____
Last First Mi

Social Security#: _____ Birthdate: _____ Drivers License# _____ Single __ Married __ Child ____

Phone # Home: (_____)_____ Business: (_____)_____ Other: (_____)_____

Address:_____
Street City State Zip Code

Contact In Case of Emergency: _____ Relationship: _____ Phone # (_____)_____

Email Address: _____

Best way to contact you (Please Circle): Email Home Phone Cell Phone Text to cell phone

How did you hear of our office? Facebook Yelp Nextdoor App Friend/Family

If someone referred you to our practice, whom may we thank? _____

Is there someone else you would like to involve in discussing dental treatment options? _____

I allow Balfour Dental to release my dental information to: my spouse _____ my physician _____other (please specify) _____

What prompted you to seek dental care at this time? _____

Do you have any anxiety about dental visits? ◯ Yes ◯ No Anxiety level (1 = no anxiety, 5 = severe anxiety) _____

What would you say is the reason for your anxiety? ◯ Needles ◯ Smell ◯ Sound ◯ Fear of Pain

Have you had any of the following?

Does your jaw click or hurt?	◯ YES	Do you smoke?	◯ YES
Do you feel you grind your teeth?	◯ YES	Do you think you have occasional bad breath?	◯ YES
Have you ever had orthodontic treatment?	◯ YES	Do your gums bleed when you brush your teeth?	◯ YES
Do you wear a night guard?	◯ YES	Do you experience sensitivity to hot / cold?	◯ YES
Have you ever had gum disease?	◯ YES	Does floss ever tear between your teeth?	◯ YES
Have you ever had your bite adjusted?	◯ YES	Does food get jammed between your teeth?	◯ YES
Do you bite your lips and cheeks often?	◯ YES	Do your teeth ever hurt when you bite hard?	◯ YES

MEDICAL HISTORY

Primary Care Physician Name _____ Date of Last Visit _____

Are you currently under the care of a Healthcare Specialist? YES NO

If yes, Name of Specialist: _____ Specialty: _____

CHECK (☑) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Disease Describe _____
- ☐ Hemophilia
- ☐ Hepatitis A, B, C (circle)
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Disease
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Ankles or Feet
- ☐ Thyroid Problems
- ☐ Tobacco Habit: How Long
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Are you, or have you taken, Bis-phosphonates or Fosamax for Osteoporosis? ⬭ YES ⬭ NO If yes, how long? _____

Are you pregnant? _____ If yes, what is the due date? _____

Do you have any other medical conditions not listed on this form? _____

Have you had any surgeries in the last 2 years? _____

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Other _____
- ☐ Penicillin
- ☐ Sulfa
- ☐ Epinephrine
- ☐ Food Allergy _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/ her staff responsible for any errors or omissions that I may have made in the completion of this form.

Our team at Balfour Dental provides the most comprehensive care and pride ourselves on maintaining an open line f communication with your physician. Recent research has proven the Oral Health has a direct correlation with Heart Disease, Heart Attacks, Strokes, Kidney Disease, Diabetes, and Immune levels. Therefore, we routinely send reports to your primary care physician or health care specialists regarding your oral health

I authorize Balfour Dental to release pertinent information and any treatment recommended to my healthcare provider.

_____ _____

Signature **(Patient / Guarantor)** **Date** **Signature (Doctor)** **Date**