

DR. ROSE M. FELICIANO

Family and Cosmetic Dentistry

2577 North First Street • San Jose, CA 95131
Tel. (408) 433-5555 • Fax (408) 433-5556

Patient Information

Last Name First Name Middle Name Mr. / Mrs. / Miss / Ms.
Nickname _____ Birthdate _____ Age _____ SS# _____ Sex: ☐ M ☐ F
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____ Length of Employment _____
Employer Address: _____ Student: ☐ Yes ☐ No Where? _____
Home Phone _____ Work Phone _____
Name of Former Dentist _____
How long since your last visit to a dentist? _____ Reason for change _____
Why are you here today? (Toothache, estimate, etc.) _____
Spouse's Name _____ Occupation _____
Employer _____

Company Street City State Zip

Account Information/Policy Holder

Last Name First Name Middle Name Mr. / Mrs. / Miss / Ms.
Mailing Address _____
Street City State Zip
Home Phone _____ Work Phone _____
Social Security # _____ D.O.B. _____ Drivers License # _____

Insurance Information

Insurance Company # 1 _____
Insurance Company #1 Address _____
Policyholder _____ SS# _____ Group Policy# _____
Insurance Company #2 _____
Insurance Company #2 Address _____
Policyholder _____ SS# _____ Group Policy# _____

Referral Information

Referred By: ☐ Pass By, ☐ Yellow Pages, ☐ Employee, ☐ Co - Worker, ☐ Friend, Name _____

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician, of insurance benefits under which I am entitled. Authorization is hereby granted to TRW and FAMILY DENTISTRY to release information for appropriate credit verification and patient information required.

Signature of Patient

Signature of Responsible Party

Name: _____

PATIENT HEALTH HISTORY

Date of last Medical Exam: _____

How would you describe your health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Others: Please describe? _____

Do you have a Medical Physician? ☐ No ☐ Yes: Name of Physician _____ Tel. # _____

1. Are you now or have you been under the care of a physician within the past five years? ☐ No ☐ Yes If so, why? _____
2. Have you had any major surgery or hospitalization? ☐ No ☐ Yes. Describe: _____ When: _____
3. Are you now or have you recently been taking any medication? If so, for what? _____
4. Have you taken Phen-fen/Redux before? ☐ No ☐ Yes When? _____ Have you seen your physician after that? _____
5. Are you allergic to or have any reactions to any of the following: **(PLEASE MARK EACH APPLICABLE BOX)**

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Novocain)			Aspirin			Iodine		
Penicillin or any other antibiotics			Codeine			Latex rubber		
Sulfa Drugs			Barbiturates			Others (please list)		
Any metals(e.g. nickel, mercury)			Sedatives					

6. WOMEN ONLY:

	Y	N
a) Are you pregnant or think you may be pregnant?		
b.) Are you nursing?		
c.) Are you practicing birth control medication?		

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: **(PLEASE MARK EACH APPLICABLE BOX)**

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement/Implant			Epilepsy or Seizures			Gonorrhea		
Heart Failure			Kidney Trouble			Glaucoma			Cold Sores		
Heart Surgery			Ulcers			Pain in Jaw Joints			Genital Herpes		
Heart Disease			Arthritis			Aids or HIV Infection			Fainting/Dizzy Spells		
Angina Pectoris			Emphysema			Liver Disease			Nervousness		
Heart Murmur			Tuberculosis			Hepatitis A (infectious)			Psychiatric Treatment		
High Blood Pressure			Asthma			Hepatitis B (serum)			Sickle Cell Disease		
Rheumatic Fever			Hay Fever/Allergies			Hepatitis C			Bleeding Gums		
Congenital Heart Defect			Sinus Trouble			Yellow Jaundice			Tooth Pain		
Scarlet Fever			Diabetes			Blood Transfusion			Bad Breath		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Headaches		
Miral Valve Prolapse			Radiation Therapy			Hemophilia			Chronic Neckaches		
Heart Pace Maker			Chemotherapy			Syphilis			Cosmetic Surgery		
Stroke			Cancer			Leukemia			Cortisone Medicine		
Others not listed:											

PATIENT DENTAL HISTORY

Name of previous Dentist and Location: _____ Date of Last Exam: _____

	Y	N		Y	N
1. Do your gums bleed while brushing or flossing?			8. Do you have frequent headaches?		
2. Are your teeth sensitive to hot or cold liquids/foods?			9. Do you clench or grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/foods?			10. Do you bite your lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?			11. Have you ever had any difficulty with extractions in the past?		
5. Do you have any sores or lumps in or near your mouth?			12. Have you had any <u>orthodontic</u> treatment?		
6. Have you had any head, neck or jaw injuries?			13. Have you ever had any prolonged bleeding following extractions?		
7. Have you ever experienced any of the following Problems in your jaw? a) Clicking			14. Do you wear dentures or partials? If yes, date of placement:		
b) Pain (joint, ear, side of face)			15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
c) Difficulty in opening or closing			16. Do you like your smile?		
d) Difficulty in chewing					

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

Signature of Patient/Parent or Guardian: _____ Date _____

Doctor's Signature: _____ Date _____

Doctor's Comments: _____

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the office of **DR. ROSE FELICIANO**.

I authorize the office of **DR. ROSE FELICIANO** to release all information necessary to secure the payment of benefits for dental treatment.

We do require definite financial arrangement prior to any treatment. Each fee is individual with the patient. For those patients with insurance, we will be happy to assist you with the billing, and with any problems that may arise. However, as your insurance is a contract between you and the insurance company, fee, allowances, deductibles and coverage's are based in this contract, therefore, **THE PATIENT IS PERSONALLY RESPONSIBLE FOR ANY AMOUNT NOT PAID BY THEIR INSURANCE CARRIER.**

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Signature of patient (parent if minor)	DATE