MARIO A. MARROQUIN DDS INC 17705 Hale Ave Suite G1 Morgan Hill, CA 95037

## PATIENT INFORMATION

Last Name Middle Name   Name Of Spouse/Partner	МО	_/_/ Sex F 🗆 N	Date Of Birth					Name
Address  Street						Name	Last	
Street E-mail @ May we Text you?: Y Home Phone				Partner	e Of Spouse/			
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Employer Occupation SS# - Driver License Emergency Contact Relationship Phone Number Who may we thank for referring you? PARENT IF MINOR  NAME DATE OF BIRTH OCCUPATION  EMPLOYER BUSINESS PHONE BUSINESS ADDRESS  DENTAL INSURANCE INFORMATION  EMPLOYEE INSURANCE COMPANY Insurance Company Ins. Address Insurance Company Ins. Address Group Number Hone of insured Insured Birthday Insured Birthday Insured Birthday Insured Birthday Insured Birthday Insured Birthday SS# SS# Employer Employer Employer Employer Employer Employer Employer Employer Overs SELF SPOUSE CHILDREN  OFFICE POLICY INFORMATION  Payment for all NEW PATIENTS and EMERGENCY visits is required at the time of service, regardless of Dental Insurance Coverage All Accounts are carried on a 30 day basis All patients are financially for their account. We are happy to file your claim to your Dental Insurance, however we are not responsible for paid from your Dental Insurance Company. A nonthly statement is mailed to each patient, even though your insurance may have been billed. A L.5% nonthly billing change will be assessed on all accounts regardless of insurance coverage after 30 days. For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS, CHECK AND CASH. There is a 5% discount for full payr CASH or CHECk at the time services are rendered I LINDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES WHETHER OR NOT PAID BY SAID DENTAL INSURANCE COMPANY. THE EVENT OF DEFAULT, 10 PAY ALL REASONABLE COLLECTION AND/OR ATTORNEY FEES.  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME  I I AM N		v we Text vou?: V	May	<b>@</b>	City	F-mail	Street	Cell Pho
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For the following questions, please  $\checkmark$  whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

PATIE	NT N	AME	DATE
			DENTAL HISTORY
PLEAS	F CTF	RCLE	DENTAL HADIONI
YES	NO		WHAT IS YOUR MAIN DENTAL CONCERN?
		ė	Do you have any pain, discomfort or impaired function related to your teeth?
		ū	Are you aware of any infection in your mouth?
	ō	ō	Are you currently taking any ANTIBIOTICS?
		ă	Do your gums ever bleed?
		ā	Do you have a problem with bad breath?
	ū	ā	Do you ever have aches or pains in your jaw joints (TMD), ears, head or neck?
_	ō	ă	Are any of your teeth tender when you chew hard foods?
ō	<u> </u>	ō	Are any of your teeth sensitive to hot, cold or sweets?
		<u> </u>	
	0		Have you had braces?
	_	ū	Have you been treated for gum disease? <b>Specialist Name</b> How often do you brush your teeth in a day?  Flossing?
		ū	
	ä		Are you interested in replacing lost teeth?  Are you interested in PORCELAIN VENEERS or IMPLANTS?
	ū		DO VOLL THE VOLD CMTLES
			DO YOU LIKE THE COLOR OF YOUR TEETH?
			Had you ever had a unpleasant dental experience?
0			
<u></u>			Do you wear removable dental appliances or dentures?
			Date of your last dental exam:Date of your last dental X-Rays
			Previous dentist name?Phone #
YE	S NO	) ?	MEDICAL HISTORY INFORMATION
		i	Active Tuberculosis, Persistent cough greater than 3 weeks or cough that produces blood?
_			RED YES TO ANY OF THE 3 ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · · · · · · · · ·
Medical	Doct	or's name	AddressPhone#
, rourea.			
			Are you in good health?
			Have there been any changes in your general health within the past year?
			Are you now under Doctor's. care?
			Have you had an organ transplant?
_			Do you have a History of Endocarditis?
_		ā	Have you had open heart surgery?
ā		ā	Have you had an orthopedic total joint (e.g. Hip, Knee,) replacement? Any metal Pins or screws?
ā		_	Has your physician recommended that you take any antibiotics prior to your dental
_	-	_	treatment?
_	0		Are you allergic to any medication? Are you interested in stopping?
_			Do you drink alcoholic beverages? If so how much: per day, week, month
Ö			Do you use any history of substance abuse or do you currently use recreational drugs?
			Do you take weight loss pills?
			DO YOU LAKE WEIGHT 1055 PHIS:
		_	WALLEY AND Y
-	NO	?	WOMEN ONLY
			Are you or could you be Pregnant?Are you taking Birth control pills or hormonal replacement?
			WARNING! Antibiotics may alter the effectiveness of hirth control nills

Please   ✓ a response to indicate if you have or have not had any of the following diseases or problems.							
	YES	NO	?		YES	NO	?
Abnormal bleeding			o	Hemophilia			Ġ
AIDS or HIV infection	ā	ū	ā	Hepatitis, jaundice or liver disease		ā	
Anemia	ā	ā		Recurrent infections			
Arthritis	ā		ā	If yes, describe		-	-
Rheumatoid arthritis			ō	Kidney problems			
Asthma				Mental health disorders	ō	ō	ō
Blood transfusion				Malnutrition	ō	ā	
Cancer, chemotherapy/Radiation				Night sweats	ā	ō	
Cardiovascular Disease				Neurological disorders	ō	ō	
Angina	Heart	murm	nur	Osteoporosis	ā	ō	
Arteriosclerosis	High b	olood	pressure	Persistent swollen glands in neck		ā	ō
Artificial heart valves			ressure	Respiratory Problems			_
Congenital heart defects			prolapse		Broncl	nitis	
Coronary artery disease	Artific			Severe headaches/migraines			
Damage heart valves	 Rheur			Severe or rapid weight loss		ō	
Heart attack				Sexually transmitted disease		ō	
Chest pain upon exertion				Sinus trouble	ā	ō	
Chronic pain				Sore or ulcers in the mouth	ō	ō	ō
Immune disease				Stroke	ā		
Diabetes Type I (insulin depe	endent) 🗆	Туре	e II	Lupus erythematosus	ā		
Dry mouth	í o	Ó		Thyroid problems			
Eating disorders				Ulcers			
Epilepsy or Seizures				Excessive urination			
Fainting spells				Gastrointestinal disease			
Glaucoma				G.E. Reflux/heartburn			
I certified that I have both read and have been answered to my satisfact take or do not take because of error	l understand tion. I will no rs or omission to Dr. Mario	the al t hold ns that Marro	bove. I ack Dr. Mario t I may ha quin and s	taff to perform those dental procedures that may be nece	for my a	action	they
Patient Signature or Legal Guardian				Date			
			FOR C	OMPLETION BY DENTIST			
Patient interview concerning	history:						
		HE	ALTH HIS	TORY UPDATE			
DATE COMMENTS				SIGNATURE OF PATIENT AND DE	NTIST		
DATE COMMENTS				SIGNATURE OF PATIENT AND DE	NTIST		-
DATE COMMENTS				SIGNATURE OF PATIENT AND DE	NTIST		
DATE COMMENTS		romanasari en estado		SIGNATURE OF PATIENT AND DE	NTIST		************

Name:			Date:	/		
Name:Date:/						
Name Of Medication	<b>Dosage</b>	When To Take	What Is For	Dr. Who Prescribed		
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