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

PATIENT INFORMATION

Name_____ Date Of Birth___/___/___ Sex **F** ❑ **M** ❑
Last Name Middle Name
I wish to be called_____ Name Of Spouse/Partner_____
Address_____
Street City State Zip
Cell Phone_____ **E-mail**_____@_____ **May we Text you?: Y** ❑ **N** ❑
Home Phone _____ Work Phone_____ Full Time Student?_____
Name of College or University
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 _____
_____
Phone Number_____
Group Number_____
Local Number_____
Name of insured_____
Insured Birthday_____
SS#_____
Employer_____
Covers ❑ SELF ❑ SPOUSE ❑ CHILDREN

EMPLOYEE INSURANCE COMPANY
Insurance Company_____
Ins. Address _____
_____
Phone Number_____
Group Number_____
Local Number _____
Name of insured_____
Insured Birthday_____
SS#_____
Employer_____
Covers ❑ 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 services not paid from your Dental Insurance Company.
- A monthly statement is mailed to each patient, even though your insurance may have been billed.
- A 1.5% monthly billing charge 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 payment by **CASH** or **CHECK** at the time services are rendered
- **I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES WHETHER OR NOT PAID BY SAID DENTAL INSURANCE COMPANY AND IN THE EVENT OF DEFAULT, TO PAY ALL REASONABLE COLLECTION AND/OR ATTORNEY FEES.**

❑ **I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME**

- ***I hereby authorize Dr. Mario Marroquin or his staff to release any and all medical and dental information of my treatment to the above named insurance carrier(s) for the purpose of pre-authorization of treatment plan and fees, claim processing, utilization review or financial audit. In addition I hereby authorize insurance payment directly to Dr. Mario Marroquin of the insurance benefits otherwise payable to our practice for services rendered .*** _____
INITIAL

SIGNED _____ **Date**_____
Responsible party if patient is a minor

For the following questions, please ✔ 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.

PATIENT NAME_____ **DATE**_____

DENTAL HISTORY

PLEASE CIRCLE YES	NO	?	
			WHAT IS YOUR MAIN DENTAL CONCERN?_____
❑	❑	❑	Do you have any pain, discomfort or impaired function related to your teeth?_____
❑	❑	❑	Are you aware of any infection in your mouth?_____
❑	❑	❑	Are you currently taking any ANTIBIOTICS? _____
❑	❑	❑	Do your gums ever bleed?_____
❑	❑	❑	Do you have a problem with bad breath?_____
❑	❑	❑	Do you ever have aches or pains in your jaw joints (TMD), ears, head or neck?_____
❑	❑	❑	Are any of your teeth tender when you chew hard foods?_____
❑	❑	❑	Are any of your teeth sensitive to hot, cold or sweets?_____
❑	❑	❑	Have you had braces?_____
❑	❑	❑	Have you been treated for gum disease? **Specialist Name** _____
❑	❑	❑	How often do you brush your teeth in a day?_____ Flossing?_____
❑	❑	❑	Are you interested in replacing lost teeth?_____
❑	❑	❑	Are you interested in **PORCELAIN VENEERS or IMPLANTS?**_____
❑	❑	❑	**DO YOU LIKE YOUR SMILE?**_____
❑	❑	❑	**DO YOU LIKE THE COLOR OF YOUR TEETH?**_____
❑	❑	❑	Had you ever had a unpleasant dental experience?_____
❑	❑	❑	Following a dental procedure have you had bleeding problems?_____
❑	❑	❑	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 #_____

MEDICAL HISTORY INFORMATION

YES	NO	?	
❑	❑	❑	Active Tuberculosis, Persistent cough greater than 3 weeks or cough that produces blood?

IF YOU ANSWERED YES TO ANY OF THE 3 ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST

Medical Doctor's name_____Address_____Phone#_____

❑	❑	❑	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?_____
❑	❑	❑	Have you had open heart surgery?_____
❑	❑	❑	Have you had an orthopedic total joint (e.g. Hip, Knee,) replacement? Any metal Pins or screws?
❑	❑	❑	**Has your physician recommended that you take any antibiotics prior to your dental treatment?**
❑	❑	❑	Are you allergic to any medication?_____
❑	❑	❑	Do you use any kind of tobacco? If so how much:_____ Are you interested in stopping?_____
❑	❑	❑	Do you drink alcoholic beverages? If so how much:_____per day, week, month_____
❑	❑	❑	Do you use any history of substance abuse or do you currently use recreational drugs?_____
❑	❑	❑	Do you take weight loss pills?_____

WOMEN ONLY

YES	NO	?	
❑	❑	❑	Are you or could you be Pregnant?_____
❑	❑	❑	Are you taking Birth control pills or hormonal replacement?_____

WARNING! Antibiotics may alter the effectiveness of birth control pills

Please ✔ a response to indicate if you have or have not had any of the following diseases or problems.

	YES	NO	?
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion_____	❑	❑	❑
Cancer, chemotherapy/Radiation	❑	❑	❑

Cardiovascular Disease

____ Angina	____ Heart murmur
____ Arteriosclerosis	____ High blood pressure
____ Artificial heart valves	____ Low blood pressure
____ Congenital heart defects	____ Mitral valve prolapse
____ Coronary artery disease	____ Artificial Valve
____ Damage heart valves	____ Rheumatic fever
____ Heart attack	

Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Immune disease	❑	❑	❑
Diabetes ❑ Type I (insulin dependent) ❑ Type II			
Dry mouth	❑	❑	❑
Eating disorders _____	❑	❑	❑
Epilepsy or Seizures	❑	❑	❑
Fainting spells	❑	❑	❑
Glaucoma	❑	❑	❑

	YES	NO	?
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent infections	❑	❑	❑
If yes, describe_____			
Kidney problems	❑	❑	❑
Mental health disorders	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑

Respiratory Problems

____ Emphysema ____ Bronchitis			
Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sore or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Lupus erythematosus	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/heartburn	❑	❑	❑

Do you have any disease, condition or problem not listed above that you think I should know about? Please explain.___

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certified that I have both read and understand the above. I acknowledge that my questions, if any, about the enquiries set forth above have been answered to my satisfaction. I will not hold Dr. Mario Marroquin or any other member of his staff, responsible for my action they take or do not take because of errors or omissions that I may have made in completion of this form.

CONSENT: I hereby grant authority to Dr. Mario Marroquin and staff to perform those dental procedures that may be necessary or advisable for diagnosis, treatment planning and completion of dental services for the above named patient.

_____ _____

Patient Signature or Legal Guardian **Date**

FOR COMPLETION BY DENTIST

Patient interview concerning history:_____

_____

_____

_____

_____

HEALTH HISTORY UPDATE

DATE	COMMENTS	SIGNATURE OF PATIENT AND DENTIST
DATE	COMMENTS	SIGNATURE OF PATIENT AND DENTIST
DATE	COMMENTS	SIGNATURE OF PATIENT AND DENTIST
DATE	COMMENTS	SIGNATURE OF PATIENT AND DENTIST

Mario A. Marroquin DDS Inc

Name:_____ Date:____/____/_____

LIST ALL MEDICATIONS: Include prescription medication, over the counter drugs, vitamins and herbal medications.

Name Of Medication	**Dosage**	**When To Take**	**What Is For**	**Dr. Who Prescribed**