JAMES P. RUSSO D.D.S.

514 ESTUDILLO AVE.
SAN LEANDRO, CA 94577

Telephone 510-483-5553
Fax 510-483-5746

About You

Today's Date: ____/____/____

Patient Name: _____
Last First Middle Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____

Social Security or ID#: _____

E-mail Address: _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other

Home Address:

_____
Street

_____
City State Zip

Home Ph: ( ) _____ Cell: ( ) _____

Work: ( ) _____ Driver's License #: _____

School: _____ Units _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Employer: _____

How long?_____ Occupation: _____

Employer's Address:

_____
Street City State Zip

Spouse Information

His/Her Name: _____

Employer: _____

Occupation: _____

Birthdate: ___/___/___ **SS or ID #:** _____

Work Ph: ( ) _____ Ext. _____

Insurance Information

Primary Insurance **Dental Coverage:** ☐Yes ☐No

Insurance Co. Name: _____
Phone: ( ) _____
Group # (Plan, Local, or Policy #): _____
Insurance Co. Address:

_____
Street /PO Box City State Zip

Insured's Name: _____

Insured's Social Security # or ID #: _____

Insured's birthdate: ____/____/____ Relation: _____

Insured's Employer: _____

Employer's Address:

_____
Street/PO Box City State Zip

Secondary Insurance **Dental Coverage:** ☐Yes ☐No

Insurance Co. Name: _____
Phone: ( ) _____
Group # (Plan, Local, or Policy #): _____
Insurance Co. Address:

_____
Street /PO Box City State Zip

Insured's Name: _____

Insured's Social Security # or ID #: _____

Insured's birthdate: ____/____/____ Relation: _____

Insured's Employer: _____

Employer's Address:

_____
Street/PO Box City State Zip

Dental History

Why have you come to the dentist today? _____

_____

Are your teeth sensitive to heat, cold, or anything else? _____

Are you currently in pain? ☐Yes ☐No
Do you have mobility in your teeth? ☐Yes ☐No

Who is your General Dentist? _____
How long? _____
Last Visit Date: _____

Do you require antibiotic pre-medication before dental treatment? ☐Yes ☐No

Your current dental health is ☐Good ☐Fair ☐Poor
Do you floss daily? ☐Yes ☐No
Do you brush daily? ☐Yes ☐No
Do your gums bleed? ☐Yes ☐No
Have you ever had periodontal disease? ☐Yes ☐No
If yes, was there any previous treatment, and when?

_____

Does your jaw ever get "out of joint" or click? ☐Yes ☐No
Have you ever had braces (orthodontics)? ☐Yes ☐No

Medical History

Do you have a personal physician? ☐Yes ☐No
Physician's Name: _____
Address:

_____
Street City State Zip

Phone #: ( )_____ Date of last visit: _____

Your current physical health is: ☐Good ☐Fair ☐Poor
Are you currently under any medical treatment? ☐Yes ☐No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you ever taken Phen-Fen, Redux, or Pondimin? ☐Yes ☐No

Have you ever taken bisphosphonates (e.g. Fosamax, Boniva, Actonel, Didronel, Skelid, Aredia, and Zometa)? ☐Yes ☐No

Are you an active member of Kaiser Permanente? ☐Yes ☐No
If yes, please provide your Kaiser member number: _____

For women: Are you taking birth control pills? ☐Yes ☐No
Are you pregnant? ☐Unsure ☐Yes ☐No
Week #: _____ Are you nursing? ☐Yes ☐No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Hepatitis (A, B, C)	Y N Radiation Treatment
Y N Alcohol Abuse	Y N Drug Abuse	Y N Herpes	Y N Rheumatic Fever
Y N Anemia	Y N Emphysema	Y N High Blood Pressure	Y N Scarlet Fever
Y N Arthritis	Y N Epilepsy	Y N High Cholesterol	Y N Seizures
Y N Artificial Bones/Joints	Y N Ever Hospitalized	Y N HIV+/AIDS	Y N Shingles
Y N Artificial Valves	Y N Fainting Spells	Y N Kidney Problems	Y N Sickle Cell Disease
Y N Asthma	Y N Fever Blisters	Y N Liver Disease	Y N Sinus Problems
Y N Blood Transfusion	Y N Glaucoma	Y N Low Blood Pressure	Y N Steroid Therapy
Y N Cancer	Y N Hay Fever	Y N Lupus	Y N Stroke
Y N Chemotherapy	Y N Headaches	Y N Mitral Valve Prolapse	Y N Thyroid Problems
Y N Chicken Pox	Y N Heart Attack	Y N Pacemaker	Y N Tonsillitis
Y N Colitis	Y N Heart Murmur	Y N Parkinson's Disease	Y N Tuberculosis (TB)
Y N Congenital Heart Defect	Y N Heart Surgery	Y N Persistent Cough	Y N Ulcers
Y N Diabetes	Y N Hemophilia	Y N Psychiatric Problems	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ☐Yes ☐No
If yes, please list each one: _____

Are you taking any over-the-counter vitamins, herbs, or supplements? ☐Yes ☐No
If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Barbiturates
Y N Dental Anesthetics	Y N Jewelry/Metals	Y N Latex	Y N Penicillin
Y N Sedatives	Y N Sulfa Drugs	Y N Tetracycline	Y N Other

Please list anything additional that causes allergic reactions: _____

Our office is HIPAA compliant, and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.
I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date Doctor Signature Date

Medical History Update

I have read my medical history dated ____/____/____ and confirmed that it states past and present medical conditions.

_____ _____
Signature Date Doctor Signature Date

KHC 1/08