Dental Fine Arts Office of Dr. Anagha Joshi
3906 Decoto Road
Fremont, CA 94555
Ph # : 510-713-7337
Fax # : 510-722-0224

Patient Personal Information

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		Student	SSN
Email		School Name	

Person responsible/guarantor for paying bills

Title	Nickname	Birth Date	Age
Last, First		Marital Status	Sex
Address		Home #	Work #
		Cell #	Drive Lic
City, State, Zip		SSN	
Email			

Do you have Primary Dental Insurance?	__ Yes __ No	**Do you have Secondary Dental Insurance?**	__ Yes __ No
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Employer Name		Employer Name	
Subscriber Last, First		Subscriber Last, First	
Subscriber Address		Subscriber Address	
City, State, Zip		City, State, Zip	
Relationship to Patient	Birth Date	Relationship to Patient	Birth Date
Subscriber ID		Subscriber ID	

Patient Medical Information

Allergic To
- [ ] No Known Allergies
- [ ] Aspirin
- [ ] Barbiturates / Sleeping Pills
- [ ] Codeine
- [ ] Erythromycin
- [ ] Iodine
- [ ] Latex Rubber
- [ ] Local Anesthetics
- [ ] Metals
- [ ] No Epinephrine
- [ ] Penicillin
- [ ] Prior Hepatitis
- [ ] Sulfa Drugs
- [ ] Other Narcotics

Check, if applicable
- [ ] No Change Since Last Recorded
- [ ] No Known Concerns or Issues
- [ ] AIDS/HIV Infection
- [ ] Alcohol/Drug Abuse
- [ ] Anemia / Leukemia
- [ ] Ankles Swell
- [ ] Anorexia / Bulimia
- [ ] Arthritis
- [ ] Asthma / Hay Fever
- [ ] Blood Clotting Problems
- [ ] Blood Transfusion
- [ ] Bronchitis
- [ ] Cancer / Tumor or Growth
- [ ] Cardiac Pacemaker
- [ ] Chest Pain Upon Exertion
- [ ] Color Blindness
- [ ] Contact Lenses
- [ ] Damaged Heart Valve
- [ ] Diabetes
- [ ] Emphysema
- [ ] Environmental Allergies
- [ ] Epilepsy
- [ ] Fainting Spells / Seizures
- [ ] Fever Blisters / Herpes
- [ ] Frequent Headaches
- [ ] Frequently Dry Mouth / Sjogren
- [ ] Gall Bladder Trouble
- [ ] Heart Attack / Stroke
- [ ] Heart Disease / Angina
- [ ] Heart Murmur
- [ ] Hepatitis / Jaundice
- [ ] High Blood Pressure
- [ ] Hives / Skin Rash
- [ ] Joint Replacement
- [ ] Kidney / Bladder Trouble
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Mental Health Problems
- [ ] Mitral Valve Prolapse
- [ ] Persistent Diarrhea
- [ ] Premedicate
- [ ] Rheumatic Fever
- [ ] Rheumatic Heart Disease
- [ ] Sexually Transmitted Disease
- [ ] Shortness of Breath
- [ ] Sinus Trouble
- [ ] Stomach Ulcers
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Unusual Weight Loss
- [ ] Urinate Frequently

Other
- [ ] See Dental Questionnaire
- [ ] See Medical Questionnaire
- [ ] See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist

Phone

Date of your last cleaning

Last exam date

Date of your last full series x-rays

Date of last cavity detection (bitewing) x-rays

Do your gums bleed while brushing or flossing ?

Are your teeth sensitive to hot, cold or sweets ?

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?

Have you ever had burning of the tongue or cracking of the corners of your mouth ?

Do you chew/smoke tobacco in any form ?

Have you had any head, neck or jaw injuries ?

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?

Do you clench or grind your teeth ?

Have you ever had orthodontic treatment ?

If Yes, date of placement

Do you wear dentures or partials ?

If Yes, date of placement of dentures ?

Are you happy with your dentures ?

Are you having any specific problems with your teeth, gums, or mouth at this time ?

Are you happy with your smile ?

Do you have problems with teeth/fillings breaking ?

Do you regularly use dental floss ?

Do you have ever been told you have Pyorrhea ?

Do you have difficulty in opening your mouth widely ?

Do you have an unpleasant taste or odor in your teeth/mouth ?

Does food catch between your teeth ?

Do you want to learn to control your dental disease and retain your teeth ?

Additional Comments

Medical Questionnaire

Medical Questionnaire

Family Physician

Phone

Are you currently under care of a Physician ?

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, what ?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Have you ever taken the diet control drug Fen-Phen ?

Do you use alcoholic beverages ?

Do you smoke ?

Women Only

Are you pregnant?

If Yes, what is your due date ?

Do you have menstrual period problems ?

Are you currently nursing ?

Are you on hormone replacement therapy ?

Are you on birth control pills / fertility drugs ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**