1_Dr. Zak Family Dentistry
4537 Alamo St.,
Suite A
Simi Valley, CA 93063
Ph # : 805-520-1100
Fax # : 805-520-9858

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			
				Referral Type			

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			
Phone #				Phone #			
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

- ☐ No Known Allergies

Allergic To

- ☐ Aspirin
- ☐ Amoxicillin
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ No Epinephrine
- ☐ Penicillin
- ☐ Prior Hepatitis
- ☐ Sulfa Drugs
- ☐ Other Narcotics
- ☐ Other Allergens

Check, if applicable

- ☐ 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
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth / Sjogren
- ☐ Gall Bladder Trouble
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ Heart Pace-maker
- ☐ Hepatitis / Jaundice
- ☐ High Blood Pressure
- ☐ Herpes/Cold Sores
- ☐ Hives / Skin Rash
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Persistent Diarrhea
- ☐ Premedicate
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Temporomandibular Joint Disord
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Unusual Weight Loss
- ☐ Urinate Frequently

Other

- ☐ See Dental Questionnaire

☐ No Change Since Last Recorded
☐ No Known Concerns or Issues
☐ Epilepsy
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ See Medical Questionnaire
☐ See Scanned Documents: Pt Note

Dental Questionnaire

Date of your last cleaning ______

Date of last exam: ______

Are you interested in regular hygiene cleanings? ______

What is the MAIN reason for your visit today?

Tooth Pain ☐

I need to check up on my dental health. ☐

Cleaning ☐

Orthodontics (brances) ☐

Whitening ☐

Cosmetic Dentistry ☐

Sedation Dentistry ☐

Other (Please describe) ______

Please indicate the extent to which you agree or disagree with the following statements.

Provide your answers on a scale of 1 to 5 (1= Strongly Disagree...5=Strongly Agree:

My overall dental health is in great condition. ______

In the last 5 years I have been very diligent about regular dental check-ups and cleanings. ______

I am very sensitive to dental procedures. ______

My gums are very sensitive during teeth cleanings ______

I feel very confident about my smile and the look of my teeth. ______

What would you like to learn more about?

Orthodontics ☐

Whitening ☐

Cosmetic Dentistry ☐

Sedation Dentistry ☐

Implants ☐

Bridges ☐

Veneers ☐

Dentures ☐

Other (Please Describe) ______

WE WOULD LIKE TO GET TO KNOW YOU BETTER

Name of previous dentist ______

Where do you work? (If patient is a child, please indicate employer of guardian) ______

Employer address

Employer phone number

How long have you worked at your current job?

Medical Questionnaire

Medical Questionnaire

Family Physician

Phone

Date of last physical exam:

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 ?

Do you wear a cardiac pacemaker, or have you had heart surgery ?

If you are allergic to any other substances not listed previously, please list belew:

Allergen #1

Allergen #2

If you are currently taking any medication please list below:

Medication #1

Medication #2

Medication #3

Medication #4

Medication #5

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

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

Have you ever been premedicated with antibiotics for your dental treatment?

If Yes, what ?

Are you using any recreational drugs (marijuana, cocaine, etc.)?

Do you smoke ?

Do you use alcoholic beverages ?

Any Disease, Condition or Problem not Listed, please list here:

Women Only

Are you pregnant?

If Yes, what is your due date ?

Are you currently nursing ?

Are you on hormone replacement therapy ?

Do you have menstrual period problems ?	☐
Are you on birth control pills / fertility drugs ?	☐
Senior Citizen	
Are you in a wheelchair?	☐
Additional Comments	
Additional Comments	______________________

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

______________________ ______________________

Patient/Guardian Signature **Date**