Welcome

Kevin Gropp, D.D.S.
9241 Reseda Blvd., Ste 101
Northridge, CA 91324
(818) 709-8645

About You

Today's Date: _____

Name: _____

I prefer to be called: _____

Birthdate: ____/____/____ Age: ____ SS #:_____

Home Address: _____

_____

___ Single ___Married ___ Divorced ___ Widowed ___ Separated

Home #:_____ Pager/Other #: _____

WK #:_____ Ext _____DL #:_____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____

email: _____

Spouse Information

His/Her Name: _____

Employer: _____

WK #: _____ Ext _____ SS #:_____

Birthdate: _____ DL #: _____

Person Responsible for Account: _____

WK #: _____ Ext _____ HM #: _____

Billing Address: _____

Relationship _____ SS #: _____

Employer: _____ DL #: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK #: _____ HM #: _____

Medical History

Do you have a personal physician? ___ No ___ Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

Medical History *continued*

Your current physical health is ___ Good ___ Fair ___ Poor

Are you currently under the care of a physician? ___ No ___ Yes

Please explain _____

Are you taking any prescription/over-the-counter drug? __No __ Yes

Please list each one _____

Have you ever had any of the following

diseases or medical problems?

Y N Heart Attack / Stroke
Y N Cancer / Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Heart Surgery / Pacemaker
Y N Shingles
Y N Mitral Value Prolapse
Y N Kidney Problems
Y N Artificial Bones / Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High / Low Blood Pressure
Y N Fever Blisters
Y N Severe / Frequent Headaches
Y N Psychiatric Problems
Y N Epilepsy / Seizures / Fainting Spells
Y N Diabetes / Tuberculosis (TB)
Y N Drug / Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia / Abnormal Bleeding
Y N Ulcers / Colitis
Y N Congenital Heart Defect
Y N Anemia / Radiation Treatment
Y N Asthma / Arthritis
Y N Difficulty Breathing
Y N Hospitalized for Any Reason
Y N Hepatitis
Y N Blood Transfusion
Y N Emphysema / Glaucoma

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs that you are allergic to: _____

_____

Are you currently pregnant? __Yes __No

Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? ___ No ___ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ___ No ___ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ___ No ___ Yes

Your current dental health is ___ Good ___ Fair ___ Poor

Do you like your smile? ___ No ___ Yes

Do your gums ever bleed? ___ No ___ Yes

How many times a week do you floss? ___ a day do you brush? ___

Type of bristles? ___ Hard ___ Medium ___ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

_____

Thank you for filling out this form completely. It will enables us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____

1. Date _____ Comments _____ Signature _____