



Thank You For Choosing Us

Nelsen Family Dentistry
1307 Esplanade, Suite 4
Chico, CA 95926
(530) 898-8511

Tell Us About You

Today's Date: _____

Name: _____ I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ____ SS#: _____ Single Married Divorced Widowed Separated

Home Address: _____ City: _____ Zip: _____

Home Phone #: () _____ Cell Phone #: () _____

Work Phone #: () _____ Drivers License #: _____

Where/when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer Address: _____

Neighbor or relative not living with you

Name: _____ Relation: _____ Home #: () _____ Work #: () _____

Address: _____

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home #: () _____ SS#: _____

Employer: _____ Work #: () _____ Drivers License #: _____

Billing Address: _____

Spouse Information

His/Her Name: _____ Birthdate: ___/___/___ Age: ____ SS#: _____

Employer: _____ Work #: () _____ Drivers License #: _____

Insurance Information

Primary Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

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

Insurance Co. Address: _____

Insured's Name: _____ Relation: _____ SS#: _____ Birthdate: ___/___/___

Insured's Employer: _____ Employer's Address: _____

Secondary Medical Coverage? Yes No Dental Coverage? Yes No Orthodontic Coverage? Yes No

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

Insurance Co. Address: _____

Insured's Name: _____ Relation: _____ SS#: _____ Birthdate: ___/___/___

Insured's Employer: _____ Employer's Address: _____

Medical History

<p>Do you have a personal physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physician's Name: _____</p> <p>Address: _____</p> <p>Phone #: _____ Date of last visit: _____</p> <p>Your current Physical Health Is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please Explain: _____</p> <p>Do you smoke or use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often? _____</p>	<p>Are you allergic to any of the following?</p> <table style="width:100%; border: none;"> <tr> <td>Aspirin</td><td>Y N</td><td>Erythromycin</td><td>Y N</td><td>Sedatives</td><td>Y N</td> </tr> <tr> <td>Barbiturates</td><td>Y N</td><td>Jewelry</td><td>Y N</td><td>Sulfa Drugs</td><td>Y N</td> </tr> <tr> <td>Codeine</td><td>Y N</td><td>Latex</td><td>Y N</td><td>Tetracycline</td><td>Y N</td> </tr> <tr> <td>Penicillin</td><td>Y N</td><td>Dental Anesthetics</td><td></td><td></td><td>Y N</td> </tr> </table> <p>Please list additional drugs that cause allergic reactions:</p> <p>_____</p>	Aspirin	Y N	Erythromycin	Y N	Sedatives	Y N	Barbiturates	Y N	Jewelry	Y N	Sulfa Drugs	Y N	Codeine	Y N	Latex	Y N	Tetracycline	Y N	Penicillin	Y N	Dental Anesthetics			Y N
Aspirin	Y N	Erythromycin	Y N	Sedatives	Y N																				
Barbiturates	Y N	Jewelry	Y N	Sulfa Drugs	Y N																				
Codeine	Y N	Latex	Y N	Tetracycline	Y N																				
Penicillin	Y N	Dental Anesthetics			Y N																				
<p>For Women: Are you taking Birth Control Pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you pregnant? <input type="checkbox"/> Unsure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Week #: _____ Are you Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																									

<p>Are you taking any of the following?</p>			
Acetaminophen <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Meds <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamines <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Remedies <input type="checkbox"/> Yes <input type="checkbox"/> No	
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis/heart Meds <input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Are you taking any prescription/over the counter drugs not listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes please list each one: _____</p> <p>Have you ever been pre-medicated prior to dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Do you have or have you experienced the following?</p>			
Abnormal Bleeding Y N	Congenital Heart Defect Y N	Heart Attack Y N	Lupus Y N
Alcohol Abuse Y N	Diabetes Y N	Heart Murmur Y N	Mitral Valve Prolapse Y N
Anemia Y N	Difficulty Breathing Y N	Heart Surgery Y N	Pacemaker Y N
Arthritis Y N	Drug Abuse Y N	Hemophilia Y N	Persistent Cough Y N
Artificial Bones/Joints Y N	Emphysema Y N	Hepatitis Y N	Psychiatric Problems Y N
Artificial Valves Y N	Epilepsy Y N	High Blood Pressure Y N	Radiation Treatment Y N
Asthma Y N	Fainting Spells Y N	HIV+/AIDS Y N	Rheumatic Fever Y N
Blood Transfusion Y N	Fever Blisters Y N	Hospitalized (any) Y N	Scarlet Fever Y N
Cancer Y N	Glaucoma Y N	Kidney Problems Y N	Seizures Y N
Chemotherapy Y N	Hay Fever Y N	Liver Disease Y N	Shingles Y N
Colitis Y N	Headaches Y N	Low Blood Pressure Y N	Sickle Cell Disease Y N
<p>Please list any serious medical conditions you have experienced: _____</p>			

Dental History

<p>1. Is there anything you'd like to change about your smile Yes No</p> <p>If so, explain: _____</p>		
<p>2. Are you having discomfort at this time? Upper: <input type="checkbox"/> Right <input type="checkbox"/> Left Lower: <input type="checkbox"/> Right <input type="checkbox"/> Left Yes No</p>		
<p>3. Have you ever had any unfavorable reaction from a local anesthetic (Novocaine, etc.)? Yes No</p>		
<p>4. Have you ever had any serious trouble associated with any previous dental treatment? Yes No</p> <p>If so, explain: _____</p>		
<p>5. How long since your last dental treatment? _____ Previous D.D.S.? _____</p>		
<p>6. Does dental treatment make you nervous? Yes No</p> <p>If YES, Check one: <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Extremely</p>		
<p><small>I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be: _____</small></p>		
<p>Date _____</p> <p>Signature _____</p>	<p>Year 3</p> <p>Health Changes _____</p> <p>Date _____ Signature _____</p>	<p>Year 5</p> <p>Health Changes _____</p> <p>Date _____ Signature _____</p>
<p>Year 2</p> <p>Health Changes _____</p> <p>Date _____ Signature _____</p>	<p>Year 4</p> <p>Health Changes _____</p> <p>Date _____ Signature _____</p>	<p>Year 6</p> <p>Health Changes _____</p> <p>Date _____ Signature _____</p>

Insurance Release

<p>I certify that I am covered by _____ Insurance Co. and I assign to Dr. Nelsen all insurance benefits otherwise payable to me. I am also responsible for paying any co-payment and deductible that my insurance does not cover at time of service. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric. I understand that I am responsible for payment of services rendered.</p>	
<p>Signature: _____</p>	<p>Date: _____</p>