Israel J. Trujillo, D.D.S.
Periodontal and Implant Specialist

PATIENT REGISTRATION

First Name:	Middle:	Last:		Sex:
Address:	City:	State/Zip:		Cell Phone#:
				( )
Date of Birth:	Social Security#:	Home Phone#:		Work#:
		( )		( )
Employer:	City:	State/Zip:	Position:	

PRIMARY INSURANCE INFORMATION

First Name:	Middle:	Last:		Sex:
Address:	City:	State/Zip:		Cell Phone#:
				( )
Date of Birth:	Social Security#:	Home Phone#:		Work#:
		( )		( )
Employer:	City:	State/Zip:	Position:	
Relationship to Patient:	Group #:	Group Name:	ID or Policy#:	

SECONDARY INSURANCE INFORMATION

First Name:	Middle:	Last:		Sex:
Address:	City:	State/Zip:		Cell Phone#:
Date of Birth:	Social Security#:	Home Phone#:		Work#:
Employer:	City:	State/Zip:	Position:	
Relationship to Patient:	Group#:	Group Name:	ID or Policy#:	

Referring Dentist:_____

Relative or friend not living with you:
Name:_____Address:_____Phone:_____

INSURANCE: I understand and agree that regardless of my personal insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. A 1 ½% finance charge will be assessed on any balance over 90 days old. I certify that all the information on this form is true and correct to the best of my knowledge and I will notify Dr. Trujillo of any changes in the above information.

APPOINTMENTS: It is necessary for you and all patients to accept and adhere to your appointment time. Dr. Trujillo and his staff have reserved that time just for you. We kindly request at least 48 hours notice be given if a cancellation is absolutely necessary. A $50 charge may be made for missed or broken appointments.

TREATMENT CONSENT: I hereby grant authority to Israel J. Trujillo, D.D.S. and his associate(s) and/or staff to administer any treatment, anesthetics, sedatives and medications and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of my periodontal and associated dental condition.

I certify that the above information is complete and accurate. I hereby authorize my insurance company(s) to pay benefits due me under the terms of my dental insurance policy directly to Israel J. Trujillo. Payment is authorized upon receipt of her itemized claim for services rendered to me. I certify that my policy was in full force and effect at the time these services were rendered.

Patient (or Guardian) Signature:_____Date:_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Compliments of
Israel J. Trujillo, DDS, APDC
Periodontics & Dental Implants

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, please check off the statements that apply to you.

Name: _____

		(Yes)	(No)
1.	I am nervous being in a dental chair.	_____	_____
2.	I have had a bad experience in a dental office.	_____	_____
3.	I sometimes get dizzy lying back in a dental chair.	_____	_____
4.	I have had difficulty with gagging or suctioning.	_____	_____
5.	I would like to take breaks during long appointments.	_____	_____
6.	My teeth or gums are very sensitive.	_____	_____
7.	I don't like dental noises such as drilling or suctioning.	_____	_____
8.	I have concerns about appointment scheduling.	_____	_____
9.	I would like extra care to relieve pain.	_____	_____
10.	I would prefer not to be lectured to by doctors.	_____	_____
11.	I will need to relay what you tell me to my spouse or another.	_____	_____
12.	I don't like shots (or have had a bad experience with them).	_____	_____
13.	I have concerns about the appearance of my teeth or smile.	_____	_____
14.	I have concerns about losing my teeth.	_____	_____
15.	I have concerns about eating, chewing, or bad breath.	_____	_____
16.	I have concerns about insurance or finances.	_____	_____
17.	I have another question or concern. (Please write it below.)	_____	_____

_____

Thank you for giving us your thoughts. Dr. Israel J. Trujillo & Staff