Steven K. Olsen D.D.S., Professional Corporation

Curt C. Facchino, D.D.S.
H. Kashani, D.M.D., M.S., M.S.
Albert Lam, D.M.D.
Shweta Prabhakar, D.D.S.
Darin T. Johnston, D.D.S.
Elham Shadmehr, D.D.S., M.S.

Russell S. Harris, D.D.S.
Nancy G. Loh, D.D.S.
Pil Han, D.M.D.
Michael Hwang, D.D.S.
Renzo Noratto, D.D.S.

Patient Information

Patient Info. Update

________ ________
Date Initials

________ ________
Date Initials

Date ____________________

Name ___________________________________
Address ___________________________________
City _________________ State _____ Zip ______
Date of Birth ________________ Age __________
Male ______________ Female _______________
Social Security # ____________________________
Driver's License # ___________________________
Married ____________ Single ____________
Employer _________________________________
Address __________________________________
City _______________ State ______ Zip ________
Position __________________________________

Cell Phone # _________________________
Work # ______________________________
Home # __________________________
Email Address _________________________
____

Spouse / Partner Information

Name _______________________________
Phone ______________________________
Address______________________________
City _____________ State _____ Zip ______

Who may we thank for referring you? ____

If you have Dental Insurance, please provide the following information so we can assist you in billing your dental insurance carrier:

Primary Carrier

Name of Insured ___________________________
Patient Relationship to Insured _______________
SS # or Member ID_________________________
Date of Birth _____________________________
Insurance Carrier __________________________
Employer _________________________________
Group # __________________________________

Secondary Carrier

Name of Insured _______________________
Patient Relationship to Insured __________
SS # or Member ID_____________________
Date of Birth ________________________
Insurance Carrier ______________________
Employer _____________________________
Group# ______________________________

General Information

Convenient Appointment Time _______________
Are you available for appointments on short notice?
___________________ Time of day ____________
Person to contact in case of emergency:
____
Their Telephone _____________________________

Person Responsible for Account _________
____
Relationship to patient ___________________
Driver's License # _____________________

Please Fill Out Both Sides Of The Form

Medical History

Please Answer All Questions

Please circle Yes or No to the following:

			If Yes, Explain:
Rheumatic Fever	NO	YES	____________________
Heart Murmur	NO	YES	____________________
High Blood Pressure	NO	YES	____________________
Circulation Problems	NO	YES	____________________
Excessive Bleeding	NO	YES	____________________
Hepatitis	NO	YES	____________________
Venereal Disease	NO	YES	____________________
AIDS	NO	YES	____________________
Anemia	NO	YES	____________________
Diabetes	NO	YES	____________________
Kidney Disease	NO	YES	____________________
Respiratory Disease	NO	YES	____________________
Tuberculosis	NO	YES	____________________
Sinus Problems	NO	YES	____________________
Asthma	NO	YES	____________________
Hay Fever	NO	YES	____________________
Ulcers	NO	YES	____________________
Arthritis	NO	YES	____________________
Tumors or Growths	NO	YES	____________________
Radiation Treatment	NO	YES	____________________
Fainting Spells	NO	YES	____________________
Nervous Disorders	NO	YES	____________________
Epilepsy	NO	YES	____________________
Head/Neck Injuries	NO	YES	____________________
Stroke	NO	YES	____________________

Are you in good health? Yes *or* No
Date of last medical exam ______________
Have you ever been hospitalized? Yes *or* No
If yes, what was the reason _____________
____
Do you wear a cardiac pacemaker? Yes *or* No
Are you under the care of a physician? Yes *or* No
If so, for what? _______________________
____
____
Are you pregnant? Yes *or* No
How many months? __________________
List any drugs or chemicals you are sensitive to:
____
Any allergies to latex? Yes *or* No
List any drugs you are now taking: _______
____
Have you ever taken Bisphosphonates? Yes *or* No
Have you ever taken Fen-Phen? Yes *or* No
Physician's Name ____________________
____
Do you have any other disease, problem or condition that you think the Doctor should know about? ________________________
____
Do you smoke? Yes *or* No -If yes, how many packs a day and for how long? _________________
Do you drink Alcohol? Yes *or* No -If yes, what is your weekly intake? ______________________

Dental History

(Please Answer All Questions)

When was the last time you saw a Dentist? ________________
Have you ever had an unfavorable experience with a Dentist?
____
____
Is there anything we can do to make you feel more comfortable while receiving treatment? Yes *or* No
____
____
Nitrous Oxide? Yes *or* No
When were your last set of x-rays taken? _________________
Have you been instructed in the care of your gums? Yes *or* No
Have you been treated for periodontal (gum) disease? Yes *or* No

Do you grind or clench your teeth? Yes *or* No
Have you ever had popping or clicking near your ear when you chew? Yes *or* No
Have you had orthodontic treatment? Yes *or* No
(example: braces or invisalign)
Do you, or have you had any dental disease problem's or condition that hasn't been mentioned? __________________________
Please explain: _______________________
Do you have any sores, blisters, or swelling on your gums, lips, or cheeks?_ Yes *or* No

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this form.

Patient or Guardian's Signature: ___________________________________ Date: ________________________

I certify that I have reviewed the medical history with the patient: ____

Doctor's Signature