

This is a fillable form: Please download first, then type your information & print.

San Diego Dental Specialists

Drs. Thurston, Lam, Amodeo

Adult Registration

Full Name _____
DOB _____ Age _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____
Mobile Phone # _____
Email Address: _____
Driver's License # _____
Business Phone# _____
Business Address _____
City _____ State _____ Zip _____

Spouse Name _____
DOB _____ Age _____
Mobile Phone # _____
Email Address: _____
Employer _____
Business Address _____
City _____ State _____ Zip _____
Business Phone _____ Ext. _____
Position _____

Who May we thank for referring you to our practice? _____
Have we treated any of your Family members? _____

Where have you seen or heard about our practice? (please check all that apply)

- Pediatrician _____ Your Dentist _____ Community Event _____
 Friend/Neighbor _____ School Sponsorship/Event _____
 Our website (www.sddentalspecialists.com)
 Yelp Facebook Internet Search Other _____

Emergency Contact Information

Name of Contact _____ Relationship _____
Phone Number _____

Insurance Information

If you would like us to assist you in filing your insurance claim please complete the following information. If you are the patient receiving care, your insurance is the primary carrier and your spouse's is the secondary. If the patient is a child (dependent), the primary carrier is the parent whose birth month is closest to the beginning of the year.

Primary Carrier

Name of Insured _____
Social Security # _____
Insurance Carrier _____
Employer _____
Group# _____ Union/Local _____
Subscriber# _____
Date of Birth _____
Relationship _____

Secondary Carrier

Name of Insured _____
Social Security # _____
Insurance Carrier _____
Employer _____
Group# _____ Union/Local _____
Subscriber# _____
Date of Birth _____
Relationship _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I consent to receiving appointment reminders via text and secured or unsecured email. Appointment reminders are not encrypted, and do not include protected health information. I understand I can withdraw my consent at any time or request an alternate method of appointment reminders

Signed (Subscriber/Parent)

Date

Registration

Patient Name _____
Date of Birth _____
Physician Address _____

Your Physician _____
Physician Phone # _____

Please check Yes No dk/u (don't know/understand) for each of the following

Now or in the past have you had:

- Yes No dk/u Birth Defects or hereditary problems?
- Yes No dk/u Bone fractures, any major accidents?
- Yes No dk/u Rheumatoid or arthritic conditions?
- Yes No dk/u Endocrine or thyroid problems?
- Yes No dk/u Kidney problems?
- Yes No dk/u Diabetes?
- Yes No dk/u Cancer, tumor, radiation treatment or chemotherapy?
- Yes No dk/u Stomach ulcers, acid reflux or heartburn?
- Yes No dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- Yes No dk/u Artificial joints or heart valves?
- Yes No dk/u Problems of the immune system?
- Yes No dk/u AIDS or HIV positive?
- Yes No dk/u Hepatitis, jaundice or liver problems?
- Yes No dk/u Fainting spells, seizures, epilepsy?
- Yes No dk/u Mental health issues or depression?
- Yes No dk/u Vision, hearing, taste or speech difficulties?
- Yes No dk/u Loss of weight recently or poor appetite?
- Yes No dk/u History of eating disorder (anorexia, bulimia)
- Yes No dk/u Excessive bleeding or bruising?
- Yes No dk/u Blood disorders, clotting problems
- Yes No dk/u High or low blood pressure?
- Yes No dk/u Chronic fatigue syndrome
- Yes No dk/u Chest pain, shortness of breath swelling in ankles
- Yes No dk/u Cardiovascular problems (heart trouble, heart attack, chest pain, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, rheumatic heart disease)
- Yes No dk/u **If yes, to the previous question**, are you required to take antibiotics prior to dental care?
- Yes No dk/u Skin disorders?
- Yes No dk/u Frequent headaches, colds or sore throats?
- Yes No dk/u Eye, ear, nose or throat condition?
- Yes No dk/u Hayfever, asthma, sinus trouble or hives?
- Yes No dk/u Are your tonsils present?
If removed, date of surgery: _____
- Yes No dk/u Osteoporosis?
- Yes No dk/u Have you taken medications for Osteoporosis ?
(Fosamax, Actonel, Boniva, Aredia, Zometa, Didronel)
- Yes No dk/u History of substance abuse?

Please list all medications and supplements you are taking

Medication _____ Dose _____

Taken for _____

Medication _____ Dose _____

Taken for _____

Medication _____ Dose _____

Taken for _____

Medication _____ Dose _____

Taken for _____

Medication _____ Dose _____

Taken for _____

Medication _____ Dose _____

Taken for _____

(If additional space is needed please ask)

Smoking

Yes No dk/u Do you smoke?

If yes: Tobacco or e-cigarettes Cannabis

For Women Only

Yes No dk/u Are you pregnant?

Yes No dk/u Are you taking birth control medication?

Allergies or reactions to any of the following:

- Yes No dk/u Local Anesthetics
- Yes No dk/u Aspirin
- Yes No dk/u Ibuprofen (Motrin, Advil)
- Yes No dk/u Acetaminophen (Tylenol)
- Yes No dk/u Penicillin or other Antibiotic _____
- Yes No dk/u Codeine or other narcotic
- Yes No dk/u Nickel or other metals _____
- Yes No dk/u Latex (gloves, balloons)
- Yes No dk/u Acrylic
- Yes No dk/u Foods _____
- Yes No dk/u Dairy
- Yes No dk/u Animals _____

Is there any other information regarding your medical history that we should know?

Patient Signature _____ Date: _____

Dentist's Signature _____ Date: _____

Medical History

Your Dentist _____
Office Phone # _____
Office Address _____

Patient Name _____
Date of Birth _____

Now or in the past, has the patient had:

- Yes No dk/u Supernumerary or extra teeth?
- Yes No dk/u Chipped or otherwise traumatized teeth?
- Yes No dk/u Sensitivity to hot or cold?
- Yes No dk/u Jaw fractures?
- Yes No dk/u Pathology of the Jaw?
- Yes No dk/u "Dead" teeth or root canal treatment?
- Yes No dk/u Bleeding gums, bad taste or mouth odor?
- Yes No dk/u Periodontal or "gum" problems?
- Yes No dk/u Food impaction between teeth?
- Yes No dk/u Frequent cold sores or ulcers?
- Yes No dk/u Tooth abscess or "gum boils"?
- Yes No dk/u Thumb, finger or sucking habits?
Until what age? _____
- Yes No dk/u Tongue thrusting?
- Yes No dk/u History of speech problems
- Yes No dk/u Mouth breathing, snoring or difficulty breathing?
- Yes No dk/u Tooth grinding or clenching of the jaw?
- Yes No dk/u Ringing of the ears?
- Yes No dk/u Any clicking, popping of your jaw joint?

Please describe:

- Yes No dk/u Any pain or soreness of the muscles of the face or around the ears?
- Yes No dk/u Difficulty chewing or jaw opening/closing?
- Yes No dk/u Had serious problems with previous treatment?
- Yes No dk/u Treatment for "TMD" or "TMJ"?
- Yes No dk/u Loose, broken, or missing fillings
- Yes No dk/u Irritations of the tongue, cheek, lip, or palate
- Yes No dk/u Problems with wisdom teeth?
- Yes No dk/u Periodontal (gum) treatment?
- Yes No dk/u Overdeveloped/Underdeveloped jaw?
- Yes No dk/u Relatives with similar jaw problems?
- Yes No dk/u Had previous orthodontic treatment?
- Yes No dk/u Are you currently in treatment?

Previous Doctors Name _____

Previous Doctors Address _____

How often do you brush? _____
How often do you floss? _____

What are your primary concerns?

CONSENT:

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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. I have thoroughly reviewed my health history. My signature below verifies that all of the necessary changes have been made.

Patient Signature _____ Date: _____

Dentist's Signature _____ Date: _____

Dental History