WELCOME TO OUR OFFICE

James E. Fitzgerald, DDS
100 Old County Road, Suite 100B, Brisbane, CA 94005
415.468.5353
email: info@jamesfitzgeralddental.com
Website: jamesfitzgeralddental.com

Patient Information

Name ____________________ Date ____________
SS# ____________________ Birth Date ____________
Address ____________________ City __________ State ______ Zip ______
Email Address ____________________ Driver's License # ____________
Home Phone ____________ Work Phone ____________ Cell Phone ____________
Employer ____________________ Address ____________________
Check appropriate box: Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Whom may we thank for sending you/How did you find us? ____________________
Emergency Contact ____________________ Phone ____________

Responsible Party Information (if different from above)

Name ____________________ Date ____________
SS# ____________________ Birth Date ____________
Address ____________________ City __________ State ______ Zip ______
Email Address ____________________ Driver's License # ____________
Home Phone ____________ Work Phone ____________ Cell Phone ____________

For your convenience we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment.

Cash ☐ Personal check ☐ Credit Card ☐ I wish to discuss the office's payment policy ☐

If Student:

Name of School/College ____________________ City ____________ State ______
Full Time ☐ Part Time ☐

Primary Dental Insurance Information

Name of Insured ____________________ Relationship to Insured: Self ☐ Spouse ☐ Child☐
SS# ____________ Birth Date ____________ Date Employed ____________
Name of Employer ____________________ Union or Local ____________
Insurance Company ____________________ Group # ____________
Ins. Co. Address ____________________ City __________ State ______ Zip ______

Do you have additional dental insurance? If yes, complete the following:

Secondary Dental Insurance Information

Name of Insured ____________________ Relationship to Patient ____________
SS# ____________ Birth Date ____________ Date Employed ____________
Name of Employer ____________________ Union or Local ____________
Insurance Company ____________________ Group # ____________
Ins. Co. Address ____________________ City __________ State ______ Zip ______

PATIENT MEDICAL HISTORY

Physician ______________________________ Office Phone ______________ Date of Last Exam _______________

1. Are you under medical treatment now? Yes ☐ No ☐ If yes, please explain ______________________
____

2. Has a physician recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐

3. Have you ever been hospitalized for any surgical operation or serious illness with the last 5 years?
Yes ☐ No ☐ If yes, please explain ____
____

4. Are you on a special diet? Yes ☐ No ☐ If yes, please explain ____________________________________
____

5. Are you taking any medication(s) including non-prescription medicine? Yes ☐ No ☐ If yes, what medication(s) are you taking? ____
____

6. Have you ever taken Fen-Phen/Redux? Yes ☐ No ☐

7. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?
Yes ☐ No ☐

8. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes ☐ No ☐

9. Do you use tobacco? Yes ☐ No ☐

10. Do you use controlled substances? Yes ☐ No ☐

11. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	Yes ☐	No ☐
Penicillin or any other antibiotics	Yes ☐	No ☐
Sulfa Drugs	Yes ☐	No ☐
Barbiturates	Yes ☐	No ☐
Sedatives	Yes ☐	No ☐
Iodine	Yes ☐	No ☐
Aspirin	Yes ☐	No ☐
Latex Rubber	Yes ☐	No ☐
Any Metals (e.g. nickel, mercury, etc.)	Yes ☐	No ☐
Other	Yes ☐	No ☐

If yes, please explain ____

12. Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)? Yes ☐ No ☐

13. Women Only:

Are you pregnant or think you may be pregnant?	Yes ☐	No ☐
Are you nursing?	Yes ☐	No ☐
Are you taking oral contraceptives?	Yes ☐	No ☐

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

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

Have you ever had any serious illness not listed above? Yes ☐ No ☐ If yes, please explain ______________

____

Comments ______________________________________

____

PATIENT DENTAL HISTORY

Name of previous dentist ____________________

Location ____________________ Date of last exam ____________________

1. Do you gums bleed while brushing or flossing? Yes ☐ No ☐
2. Are your teeth sensitive to hot or cold liquids/foods? Yes ☐ No ☐
3. Are your teeth sensitive to sweet or sour liquids/foods? Yes ☐ No ☐
4. Do you feel pain in any of your teeth? Yes ☐ No ☐
5. Do you have any sores or lumps in or near your mouth? Yes ☐ No ☐
6. Have you have any head, neck or jaw injuries? Yes ☐ No ☐
7. Have you ever experienced any of the following problems in your jaw:
   - Clicking Yes ☐ No ☐
   - Pain (joint, ear, side, face) Yes ☐ No ☐
   - Difficulty in opening or closing Yes ☐ No ☐
   - Difficulty in chewing Yes ☐ No ☐
8. Do you have frequent headaches? Yes ☐ No ☐
9. Do you clench or grind your teeth? Yes ☐ No ☐
10. Do you bite your lips or cheeks frequently? Yes ☐ No ☐
11. Have you ever had any difficult extractions in the past? Yes ☐ No ☐
12. Have you ever had any prolonged bleeding following extractions? Yes ☐ No ☐
13. Have you had any orthodontic (braces) treatment? Yes ☐ No ☐
14. Do you wear dentures or partials? Yes ☐ No ☐
    If yes, date of placement ____________________
15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums? Yes ☐ No ☐
16. Have you ever received periodontal (gum) scaling or surgery? Yes ☐ No ☐
    If yes, when? ____________________
17. Do you like your smile? Yes ☐ No ☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize James E. Fitzgerald DDS Inc. to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible to payment of all services rendered on my behalf or my dependents.

____________________ Date ____________________

Signature of patient (or parent/guardian if patient is a minor)

Additional Statement

Not all services are covered by insurance. In the event your insurance plan determines a service is not covered, you will be responsible for the complete charge. Our staff cannot guarantee your eligibility and coverage. Insurance rules and limits vary with insurance plans.

If the dentist determines there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I therefore authorize the dentist to contact my physician if necessary.

By consenting to treatment, you understand that the use of anesthetic agents embodies certain risks. If you have any concerns about potential complications, please do not hesitate to ask.

Late Cancellations

A fee of $25.00 per 30 minutes will be charged for all appointment cancellations made without a 24-hour notice.

Late Charges

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the unpaid balance will be assessed monthly. Please note that failure to keep this account current may result in us being unable to provide additional dental services, except for dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, the patient will be responsible for collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

I certify that I have read and understand the above information to the best of my knowledge.

____ Date ________________

Signature of patient (or parent/guardian if patient is a minor)