

WELCOME TO OUR OFFICE

James E. Fitzgerald, DDS , Inc.
100 Old County Road, Suite 100B, Brisbane, CA 94005
415.468.5353

email: info@jamesfitzgeraldental.com
Website: brisbanefamilydental.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 within 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 <input type="checkbox"/> No <input type="checkbox"/>
Penicillin or any other antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sulfa Drugs	Yes <input type="checkbox"/> No <input type="checkbox"/>
Barbiturates	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sedatives	Yes <input type="checkbox"/> No <input type="checkbox"/>
Iodine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Aspirin	Yes <input type="checkbox"/> No <input type="checkbox"/>
Latex Rubber	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any Metals (e.g. nickel, mercury, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>
Are you nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you taking oral contraceptives?	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

<p>AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cold Sores/ Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy/ Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells/ Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack/ Failure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble/ Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis B/C <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hives/Rash <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach/ Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tumors/ Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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 your gums bleed while brushing or flossing? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Do you feel pain in any of your teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Have you have any head, neck, or jaw injuries? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw: | |
| Clicking | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pain (joint, ear, side, face) | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Difficulty in opening or closing | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Difficulty in chewing | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Do you have frequent headaches? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Do you clench or grind your teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Do you bite your lips or cheeks frequently? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Have you ever had any difficult extractions in the past? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Have you ever had any prolonged bleeding following extractions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Have you had any orthodontic (braces) treatment? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. Do you wear dentures or partials? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, date of placement _____ | |
| 15. Have you ever received oral hygiene instructions regarding the care of your teeth or gums? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 16. Have you ever received periodontal (gum) scaling or surgery? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If yes, when? _____ | |
| 17. Do you like your smile? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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 for payment of all services rendered on my behalf or my dependents.

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

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

Appointments cancelled less than 24 hours in advance will incur a late cancellation fee of \$25.00 per 30 minutes of scheduled appointment time.

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 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 this amount or any future outstanding balances.

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

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

Date