The Office Of
David A. Newsham, D.D.S.
1735 North Riverside Avenue
Rialto, California 92376

(909) 820-9081 Tel.
(909) 820-9083 Fax.

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767/27000

X _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

_____
PATIENT NUMBER

MEDICAL HISTORY

Physician_____ Office Phone_____ Last Exam_____

Are you allergic to or have had any reactions to the following?

Local Anesthetics (eg. Novocain) ____Y ____N
Penicillin or any other antibiotics ____Y ____N
Sulfa Drugs ____Y ____N
Barbiturates ____Y ____N
Sedatives ____Y ____N
Iodine ____Y ____N
Aspirin ____Y ____N
Any Metals (nickel, mercury, etc) ____Y ____N
Latex Rubber ____Y ____N
Other_____

Are you under treatment now for a medical Condition? ____Y ____N
Have you been hospitalized within the last 5 years? ____Y ____N
Explain_____

Are you, or have you ever taken Bisphosphonates for Osteoporosis, Multiple Myeloma, or other cancers (Reclast, Foxomax, Actonel, Boniva, Aredia, or Zometa ? ____Y ____N
Are you taking medications at this time? ____Y ____N
Prescribed, Over the Counter or Herbal?_____

Do you use controlled substance? ____Y ____N
Do you use tobacco? ____Y ____N

Do you have now or previously had the following?

High/Low Blood Pressure ____Y ____N
Heart Murmur ____Y ____N
Cardiac Pacemaker ____Y ____N
Joint Replacement/Implant ____Y ____N
Seizures/Epilepsy ____Y ____N
Asthma ____Y ____N
Diabetes ____Y ____N
Hepatitis ____Y ____N
Aids or HIV Infection ____Y ____N
Emphysema ____Y ____N
Sexually Transmitted Disease ____Y ____N
Stroke ____Y ____N
Radiation Therapy ____Y ____N
Liver Disease ____Y ____N
Osteoporosis ____Y ____N
Other_____ ____Y ____N

Heart Attack ____Y ____N
Mitral Valve Prolapse ____Y ____N
Rheumatic Fever ____Y ____N
Heart Trouble ____Y ____N
Angina ____Y ____N
Anemia ____Y ____N
Kidney Disease ____Y ____N
Cancer ____Y ____N
Thyroid Problem ____Y ____N
Arthritis ____Y ____N
Stomach Trouble/Ulcers ____Y ____N
Tuberculosis ____Y ____N
Glaucoma ____Y ____N
Respiratory Problems ____Y ____N
Are you pregnant or think you may be? ____Y ____N
Are you Nursing? ____Y ____N

DENTAL HISTORY

Name of Previous Dentist_____ Last Check Up_____

Do your gums bleed? ____Y ____N
Are your teeth sensitive? ____Y ____N
Do you have pain? ____Y ____N
Have you had injuries to your Head, neck or jaw? ____Y ____N
Do you have problems in your jaw
Clicking / chewing ____Y ____N
Pain in joint / ears ____Y ____N
Do you like your smile? ____Y ____N

Do you have frequent headaches? ____Y ____N
Do you clench or grind your teeth? ____Y ____N
Do you have sores in your mouth? ____Y ____N
Do you have prolonged bleeding after extraction? ____Y ____N

Do you wear dentures/partials? ____Y ____N
Do you have difficulty chewing? ____Y ____N
Have you received Oral Hygiene instruction? ____Y ____N

Authorization of Treatment, Release of Information and Acceptance of Responsibility

I certify that I have read and understand the above information and have answered the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I have been informed and agree to treatment that the doctor has diagnosed. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payor and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual estimate for services and understand that the contract is between myself and my insurance company. I understand and agree that I am responsible for the full payment at the time services are rendered on my behalf or my dependents regardless of the dental insurance coverage I have.

Signed_____ Date_____

Signed_____ Date_____

Doctor's Signature_____ Date_____

Doctor's Signature_____ Date_____