MYRNA E. LAZAGA DMD.

12307 Oak Knoll Road, Suite A
Poway, CA 92064
(858) 486-4222

914 East 8th Street, Suite 208
National City, CA 91950
(619) 477-0570

Welcome to our office. We appreciate the confidence you place with us to provide you with dental services. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions, don't hesitate to ask.

Patient Name:_____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (If different): _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Driver's License #: _____ State: _____ Social Security #: _____

Spouse's Name & Phone #: _____ Email: _____

Employer/Occupation: _____ Emergency Contact & Phone:_____

Primary Dental Insurance: _____ Secondary Insurance (If any): _____

Subscribers Name: _____ Date of Birth: _____ S.S. #: _____

Name of Primary Physician: _____ Physician Phone #: _____

Name of Previous Dentist: _____ Date of last visit to Dentist: _____

How did you learn of our office? _____

DENTAL HEALTH HISTORY

Please Mark any that Apply:	Yes	No	Please Mark any that Apply:	Yes	No
Are you apprehensive about dental treatment?			How often do you brush?		
Have you had problems with previous dental treatment?			How often do you floss?		
Do you gag easily?			Does your jaw make noises so that it bothers you or others?		
Do you wear dentures?			Do you clench or grind your jaws frequently?		
Does food catch between your teeth?			Does your jaw ever feel tired?		
Do you have difficulty chewing your foods?			Does your jaw get stuck so that you can't open freely?		
Do you chew on only one side of your mouth?			Does it hurt when you chew or open wide to take a bite?		
Do you avoid brushing any areas due to pain?			Do you have earaches or pain in front of the ears?		
Do your gums bleed easily?			Do you have any jaw symptoms or headaches upon waking in the morning?		
Do your gums bleed when you floss?					
Do your gums feel swollen or tender?			Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?		
Are your teeth sensitive?					
Have you ever noticed slow-healing sores in or about your mouth?			Do you find jaw pain or discomfort extremely frustrating or depressing?		
Do you feel twinges of pain when your teeth come in contact with:			Do you take medications or pills for pain or discomfort? (pain relievers, muscle relaxants, antidepressants)		
- Hot foods or liquids?			Do you have temporomandibular jaw disorder? (TMD, TMJ)		
- Cold foods or liquids?			Do you have pain in the face, cheeks, jaws, joints, throat or temples?		
- Sours?					
- Sweets?			Are you unable to open your mouth as far as you want?		
Do you take fluoride supplements?			Are you aware of an uncomfortable bite?		
Are you dissatisfied with the appearance of your teeth?			Have you had a blow to the jaw (trauma)?		
Do you prefer to save your teeth?			Are you a habitual gum chewer or pipe smoker?		
Do you want complete dental care?					

MEDICAL HEALTH HISTORY

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

Please mark any that apply.	Yes	No
Heart problems		
Chest pain		
Shortness of breath		
Blood pressure problems		
Heart Murmur		
Heart valve problem		
Taking heart medication		
Rheumatic fever		
Pacemaker		
Artificial heart valve		
Blood problems		
Easy bruising		
Frequent nosebleeds		
Abnormal bleeding		
Blood disease (anemia)		
Ever required blood transfusion		
Allergy Problems		
Hay fever		
Sinus problems		
Skin rashes		
Taking allergy medication		
Asthma		
Intestinal problems		
Ulcers		
Weight gain or loss		
Special diet		
Constipation/Diarrhea		
Kidney or bladder problems		
Bone or joint problems		
Arthritis		
Back or neck pain		
Joint replacement (e.g. hip, pins, implants)		
Fainting spells, seizures, or epilepsy		
Frequent or sever headaches		
Thyroid problems		
Persistent cough or swollen glands		
Premeditation required by physician		
Cancer/tumor		

Are you allergic, or have you reacted adversely to any of the following?

Local anesthetics (Novocain)		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates, sedatives, or sleeping pills		
Aspirin, acetaminophen, or ibuprofen		
Codeine, Demerol, or other narcotics		
Reaction to metals		
Latex or rubber dam		

Other (please list)

Please mark any that apply	Yes	No
Diabetes		
Urinate more than 6 times a day		
Thirsty or mouth is dry much of the time		
Family history of diabetes		
Tuberculosis or other respiratory disease		
Do you drink alcohol?		
If so, how much		
Do you smoke		
If so, how much		
Hepatitis, jaundice, or liver trouble		
Herpes or other STD's		
HIV positive/AIDS		
Glaucoma		
Do you wear contact lenses		
History of head injury		
Epilepsy or other neurological disease		
History of alcohol or drug abuse		
Do you have any disease, condition, or problems not listed previously that you feel we should know about?		
If so, please describe		

During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs		
Anticoagulants (e.g. Coumadin)		
High blood pressure medicine		
Tranquilizer		
Insulin, Orinase, or similar drug		
Aspirin		
Digitalis or drugs for heart trouble		
Nitroglycerin		
Cortisone (steroids)		
Bisphosphonates (e.g. Fosamax, Boniva, Actonel)		
Natural Remedies		
Nonprescription drug/supplements		

Other

Women

Are you taking contraceptives or other hormones		
Are you pregnant		
If so, expected delivery date		
Are you nursing		
Have you reached menopause		
If so, do you have symptoms		

(please describe)

Patient/Guardian Signature _____ Date _____ Dentist Initial _____