Welcome to

The Dental Office of Jaime Rojas, DDS
78640 Highway 111
La Quinta, CA 92253
Phone: (760)564-0955

Patient Information…

Today's Date: _____

Patient Name: _____ ❑ Male ❑ Female
Last First MI

What You Prefer To Be Called: _____ Birth Date: ___/___/_____ Age: _____ SS#: _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

E-mail Address: _____ Referred By: _____

Employer: _____ Occupation _____ How Long? _____

Employer's Address: _____ City _____ State _____ Zip _____

Status: ❑ Single ❑ Married ❑ Minor ❑ Other **Spouse/Parent/Guardian Name:** _____

In Case of Emergency, Please Contact: _____ Relation: _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Who Will Be Responsible For Your Account: _____ **Relation:** _____

Address: _____ Phone: _____

Primary Dental Insurance

Insured's Name: _____

Relation _____ D.O.B. _____

Employer: _____

Address: _____

City _____ State ___ Zip _____

Insurance Co. _____

Address _____

City/State/Zip _____

Phone # (___) _____

ID or SS # _____ Group# _____

Secondary Dental Insurance

Insured's Name: _____

Relation _____ D.O.B. _____

Employer: _____

Address: _____

City _____ State ___ Zip _____

Insurance Co. _____

Address _____

City/State/Zip _____

Phone # (___) _____

ID or SS # _____ Group# _____

Dental Information

Reason for today's visit?_____ Are you in pain? ❑Yes ❑No How long?_____

Please indicate any of the following problems, conditions, or treatment by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Teeth grinding ❑Clenching
❑ Difficulty closing or opening jaw
❑ Locking jaw
❑ Ringing in ears
❑Lost /broken filling(s)

❑ Broken/chipped tooth
❑ Loose/shifting teeth
❑ Food caught between teeth
❑ Toothache
❑ Stained teeth
❑ Red, swollen, or bleeding gums

❑ Blisters/sores in or around the mouth
❑ Swelling/lumps in mouth
❑ Burning tongue/lips
❑ Bad breath
❑Gum Disease
❑ Orthodontics
❑ A removable dental appliance

❑ Sensitive teeth:
❑Hot ❑Cold
❑ Sweets ❑ Biting
❑ Jaw Problems: TMJ/TMD
❑ Snoring/Sleep Problems
❑Other _____

Last dental exam: _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristle do you use? ❑ Soft ❑ Medium ❑ Hard Previous Dentist:_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Phone# (_____)_____

Medical History

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

Do you have or have you had any of the following diseases, medical conditions, or procedures? PLEASE CHECK ALL THAT APPLY.

❑ Heart Attack or Stroke
❑ Heart Surgery_____
❑ Pacemaker
❑ Heart Murmur
❑ Mitral Valve Prolapse
❑ Artificial Valves
❑ Rheumatic Fever
❑ Chest Pains/Angina
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Congenital Heart Defect
❑ Scarlet Fever

❑ Diabetes
❑ Hypoglycemia
❑ Anemia
❑ Thyroid Problems
❑ Kidney Problems
❑ Dialysis
❑ Asthma
❑ Respiratory Problems
❑ Emphysema
❑ Stomach Problems/Ulcers
❑ Sinus Problems
❑ Tuberculosis

❑ Nervousness
❑ Psychiatric Problems
❑ Venereal Disease/STD
❑ Alcohol or Drug Abuse
❑ Hepatitis_____
❑ HIV+/AIDS/ARC
❑ Shingles
❑ Cancer
❑ Tumor or Growth
❑Radiation/Chemotherapy/ Cobalt Treatment
❑ Leukemia

❑ Fainting/Seizures/Epilepsy
❑ Severe/Frequent Headaches
❑ Arthritis/Rheumatism
❑ Artificial Bones/Joints_____
❑ Cosmetic Surgery
❑ Frequent Neck Pain
❑ Back Problems
❑ Bleeding Problems
❑ Glaucoma
❑ Contact Lenses

Please list any other surgeries or medical conditions you have or ever had:_____

_____

What medications are you currently taking?

❑ Blood Thinners_____
❑ Pain Killers (including aspirin)_____
❑Nerve Pills
❑ Muscle Relaxers _____
❑ Stimulants

❑ Antidepressants_____
❑ Insulin
❑ Tranquilizers
❑ Diet Pills

❑ **Are you now taking or have you ever taken:** bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, or Boniva)
❑ Other(s):_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Aspirin ❑ Codeine ❑ Sulfa drugs
❑ Dental Anesthetics ❑ Foods _____ Other:_____

For Women: Are you pregnant ❑No ❑Yes/How long_____ Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No How many children have you had?_____

- I understand the above information and guarantee this was completed to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have been given the opportunity to review the Financial Policy for the Office of Jaime Rojas, DDS, Inc (a copy of this policy will be given upon request). Our policy requires payment in full for all services rendered at the time of visit
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

⌦ _____ ❑Adult Patient ❑Parent/Guardian **Date** _____