SPECKMAN DENTAL

James A. Speckman, DMD
4080 Loma Vista, Suite B, Ventura, CA 93003
805-644-9751

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Middle Initial: _____ Preferred Name: _____

Birthday (MM/DD/YYYY): _____ Social Sec. Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Name of Employer/School (if student): _____

Name of Parent/Guardian (if under 18): _____

Parent/Guardian Address (if different): _____

City: _____ State: _____ Zip: _____

Phone (if different): _____

Name of Spouse: _____ Spouse's Employer: _____

Emergency Contact Person: _____

Relationship: _____ Emergency Contact Phone: _____

How did you hear about our office? _____

_____

INSURANCE INFORMATION

Name of Insured: _____ Birthday or Insured (MM/DD/YYYY): _____

Social Sec of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Insurance Company: _____

Group Name: _____ Group #: _____ Insurance ID #: _____

DENTAL/MEDICAL HISTORY

Former Dentist: _____ Phone: _____

Reason for today's visit: _____

Date of last exam: _____ Date of last dental x-rays: _____

How often do you brush? _____ Floss? _____

Please check the following that apply to you:

☐ Bad breath ☐ Grinding/clenching teeth ☐ Sensitivity to biting

☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Clicking/popping jaw

☐ Sensitivity to cold or hot ☐ Food collects between teeth

I'd like more information on:

☐ Braces ☐ Teeth whitening

☐ Tooth colored restorations ☐ Cosmetic procedures

Primary Care Physician: _____

Date of last medical visit: _____ Physician Phone: _____

Are you presently under your physician's care? ☐ Yes ☐ No

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

Have you ever had a serious head or neck injury? ☐ Yes ☐ No

Are you taking any medication, pills or drugs? ☐ Yes ☐ No

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptive?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Other _____

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

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heat Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headache
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Thirst
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ 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 or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had a serious illness not listed above? Explain: _____

Comments:

Signature of Patient, Parent or Guardian: _____

Date: _____