Allan P. Capinpin, D.D.S.

PATIENT INFORMATION

Today's Date______________________

(Please check in the box next to the best way(s) to reach you)

Name___________________________________

Address_________________________________

____

City State Zip

☐ Home Phone( )________________________

☐ Cell Phone ( ) ________________________

☐ E-mail____________________________________

☐ Text to cell is ok

Gender Male Female

Birth date_____/_____/___________ Age_______

Single *Married Widowed Divorced

Social Security #______________________

Employer_________________________________

Employer Phone ( )______________________

*INFORMATION ABOUT YOUR SPOUSE

Name_____________________________________

Birth date_____/_____/___________

Employer_________________________________

Employer Phone ( )______________________

As a courtesy service to our patients, we will bill your insurance company, as long as you have provided all necessary information. Your insurance policy is a contract between you, your employer and the insurance company. Insurance policies vary and services provided may not be covered. We cannot guarantee insurance payment, as the insurance carrier will not guarantee payment before a claim is received. Please contact your employer or insurance carrier if you have questions about your policy coverage.

PRIMARY CARRIER

(Self, unless you do not have your own coverage)

Name of Insured___________________________

Relationship ______________________________

Birthdate_________________________________

Insurance Company_______________________

ID/Social Security #_________________________

SECONDARY CARRIER

(Spouse, if you have your own coverage)

Name of Insured___________________________

Relationship ______________________________

Birthdate_________________________________

Insurance Company_______________________

ID/Social Security#_________________________

I, the undersigned certify that I(or my dependant) have insurance coverage with ______________________and assign directly to **Dr. Capinpin** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Capinpin to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions. ____________________________ ________________________________ ___________________________________

Signature Date Relationship (to subscriber)

GENERAL INFORMATION

Whom may we thank for referring you? ________________________________

Are you available for appointment on short notice? _________

Contact ___________________________ in case of an emergency. Phone( )____________________

CONSENT FOR DENTAL TREATMENT

I hereby give consent to any advisable and necessary dental procedures, medications, anesthetics or necessary radiographs (x-rays), to be administered by Dr. Allan Capinpin or the supervised licensed staff for diagnosis and treatment of my dental condition.

__________________________________ __________________________________

Patient/Guardian Signature Date

(Continued on back)

Patients Name:

MEDICAL HISTORY

Physician's Name_____________________ Kaiser ID#__________________ Phone (   )____________

Have you been under the care of a medical doctor during the past two years? .... Yes No

If yes, for what____

Have you been a patient in the hospital during the past five years? .... Yes No

If yes, for what____

Due to constant changes in the medical and dental health fields it is very important of Dr. Capinpin to know about your over all health. **Please circle "yes" or "no" if you have or have had any of the following:**

yes no **Anemia**
yes no **Angina Pectoris**
yes no **Arthritis/Rheumatism**
yes no **Artificial Heart Valve**
yes no **Artificial Joints (hip, knee)**
yes no **Asthma**
yes no **Back Problems**
yes no **Blood Transfusion**
yes no **BRONJ**
yes no **Bruise Easily**
yes no **Cancer**
yes no **Chemotherapy**
yes no **Chest Pain**
yes no **Chronic Cough**
yes no **Cold Sores/Fever Blisters**
yes no **Congenital Heart Disease**
yes no **Contact Lens**
yes no **Cortisone Treatments**

yes no **Diet (special, restricted)**
yes no **Diabetes**
yes no **Eating Disorders**
yes no **Emphysema**
yes no **Epilepsy/Seizures**
yes no **Fainting/Dizzy Spells**
yes no **Glaucoma**
yes no **Headaches**
yes no **Heart Disorder**
yes no **Heart Infection**
yes no **Heart Valve Replacement**
yes no **High Blood Pressure**
yes no **Heart Pacemaker**
yes no **Hay Fever**
yes no **Hepatitis (a, b, c)**
yes no **Hemophilia**
yes no **H.I.V/A.I.D.S**
yes no **Kidney Trouble**

yes no **Liver Disease**
yes no **Nervous/Anxious**
yes no **Neurological Disorders**
yes no **Psychiatric Care**
yes no **Psychological Care**
yes no **Radiation Therapy**
yes no **Swollen Ankles**
yes no **S.T.D.**
yes no **Stroke**
yes no **Sinus Trouble**
yes no **Sickle Cell Disease**
yes no **Thyroid (high, low)**
yes no **Tuberculosis**
yes no **Tumors**
yes no **Ulcers**
yes no **Yellow Jaundice**

Any other conditions not listed? ____

MEDICATIONS

List medications you are currently taking ____

List herbal remedies or vitamins you take ____

ALLERGIES

Are you aware of having an allergic (or adverse reaction) to any medications or substance? __________

If yes, please list ____

Have you ever had IV Bisphosphonate Therapy? .... Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin/Adipex/ Fastin(brand name for phentermine), Pondimin (fenfluramine),and Redux (dexfenfluramine).. Yes No

Have you lost or gained more than 10 pounds in the past year? .... Yes No

Do you use more than two pillows to sleep?.. Yes No

Do you smoke or use other tobacco products.. Yes No

WOMEN

Are you: Pregnant? ....Yes (months____________) Nursing? .... Yes No

Taking Birth control Pills? .... Yes No

Using oral Bisphosphonate for Hormone Replacement Therapy (Fosamax,Actonel,Boniva)?... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and I understand that it is my responsibility to inform the doctor if I ever have a change in health or medication.

_______________________________ _______________________

Patient/Guardian Signature **Date**

Dr. Capinpin has reviewed the above health history with the patient. _______________________________

Signature **Date**