

# Forrest R. Boozer, DDS

2530 Cameo Drive  
Cameron Park, Ca 95682  
Phone: (530) 676-9999

[www.cameronparkdds.com](http://www.cameronparkdds.com)

“We Keep You Smiling”

## Welcome

*We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.*

*We look forward to working with in maintaining your dental health.*

### Patient Information

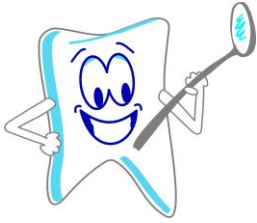
Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Last Name First Name Initial  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Sex    M    F  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single    Married    Widowed    Separated    Divorced     
 Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Email \_\_\_\_\_

### Primary Insurance

Person Responsible for Account \_\_\_\_\_  
 Last Name First Name Initial  
 Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Person Responsible Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insurance Email \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Name of other dependants under this plan \_\_\_\_\_

### Additional Insurance

Is patient covered by additional insurance? Yes    No     
 Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Subscriber Employed By \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Business Email \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insurance Email \_\_\_\_\_  
 Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Name of other dependants on this plan \_\_\_\_\_



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## Dental History

What would you like us to do today? \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Email \_\_\_\_\_

Date of last Dental Care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

Check if you have had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad Breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food Collection between Teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to Hot        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal Treatment   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold            | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Other information about your dental health or previous treatment \_\_\_\_\_

## Medical History

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations?  Y  N

If yes, describe \_\_\_\_\_

Are you currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Y  N If yes, give approximate dates \_\_\_\_\_

Have you ever taken Fen-Phen/Redux?  Y  N

Women: Are you pregnant?  Y  N Nursing?  Y  N Taking birth control pills?  Y  N

Check yes or no if you have had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive       | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting                      | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Care               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis             | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies                | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma                      | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism   | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches                     | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                  | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Joints       | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems                | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | Describe _____  | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone)  | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal Bleeding  | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems           | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes                        | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease           | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                     | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                  | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure           | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency     | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Pain                      | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy            | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease or Malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease                 | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Habit                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Treatments    | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies            | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, Persistent       | (latex, wool, metal, chemicals)   | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood          | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse         | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous Problems              | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy                | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/heart surgery       |  |

Is patient currently taking any medications? If yes, list all: \_\_\_\_\_

Does patient have drug allergies? If yes, list all: \_\_\_\_\_

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Payment is due in full at time of treatment, unless prior arrangements have been approved.*