



795 Alamo Pintado Road
Solvang, CA 93463
(805) 688-2269

Patient Information:

Name of Patient: _____ Date: _____
Address: _____
City: _____ Zip: _____ E-Mail: _____
Mailing Address (if different): _____
Home Phone: _____ Work or Cell: _____
Employed by: _____ Position: _____
Social Security #: _____
Date of Birth: _____ Age _____

History:

1. Do you normally require premedication before treatment? Yes _____ No _____
2. Do you have a history of:
 - Prolonged bleeding? Yes _____ No _____
 - Rheumatic fever, heart murmur, or diabetes? Yes _____ No _____
 - Joint or heart valve replacement? Yes _____ No _____
3. Reaction to anesthetic drugs? Yes _____ No _____
4. Do you have any disease, condition, or problem not listed the doctor should know about? _____
5. Allergies to any drugs or medication? _____
6. If there were a simple way to whiten your teeth, would you be interested? _____
7. Whom may we thank for your referral? _____

I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Responsible Party: **X** _____