MATTHEW CILDERMAN, DDS
Family & Cosmetic Dentistry

4848 Lakeview Avenue, Suite 102
Yorba Linda, California 92886

Welcome to our office

About You

Today's Date _____

Patient Name

_____
Last First M

What You Prefer to be Called _____
Birthdate _____ Age _____
Social Security # _____
Mailing Address _____

_____
City State Zip

Home Phone # _____
Work Phone # _____
Cell Phone # _____
e-mail Address _____

Referred By _____

Employer _____
How Long? _____
Employer's Address _____

_____
City State Zip

Occupation _____

Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Spouse's Name _____

Do you have children? Yes ☐ No ☐ How many? _____

Account Information

Person responsible for account

Name _____
Relationship _____
Billing Address _____

_____
City State Zip

Social Security # _____
Drivers License # _____
Work Phone # _____
Home Phone # _____

Insurance Information

Primary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

Secondary Dental Insurance

Insurance Carrier _____
Group Plan # _____
Phone # _____
Insured's Name _____
Relation _____
Date of Birth _____
Insured's SS# _____
Insured's Employer _____

In Event of Emergency

Who should we contact? _____
Relationship: _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____
Who is your MEDICAL DR.? _____
M.D.'s Phone # _____

Please continue on back →

MATTHEW CILDERMAN, DDS
Family & Cosmetic Dentistry

4848 Lakeview Avenue, Suite 102
Yorba Linda, California 92886

Dental History

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

Former Dentist _____ Address _____

Dentist's Email_____ Phone_____

Date of last dental care_____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑Y ❑N Bad breath	❑Y ❑N Food collection between teeth	❑Y ❑N Periodontal treatment	❑Y ❑N Sensitivity to sweets
❑Y ❑N Bleeding gums	❑Y ❑N Grinding or clenching teeth	❑Y ❑N Sensitivity to cold	❑Y ❑N Sensitivity when biting
❑Y ❑N Clicking or popping jaw	❑Y ❑N Loose teeth or broken fillings	❑Y ❑N Sensitivity to hot	❑Y ❑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

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑Y ❑N

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

Check (✓) yes or no whether you have had any of the following:

❑Y ❑N AIDS/HIV Positive
❑Y ❑N Alzheimer's/Dementia
❑Y ❑N Anaphylaxis
❑Y ❑N Anemia
❑Y ❑N Arthritis, Rheumatism
❑Y ❑N Artificial heart valves
❑Y ❑N Artificial joints
❑Y ❑N Asthma
❑Y ❑N Atopic (allergy prone)
❑Y ❑N Autoimmune Disorder
❑Y ❑N Back problems
❑Y ❑N Blood disease
❑Y ❑N Cancer
Describe _____
❑Y ❑N Chemical dependency
❑Y ❑N Chemotherapy

❑Y ❑N Circulatory problems
❑Y ❑N Cortisone treatments
❑Y ❑N Cough, persistent
❑Y ❑N Cough up blood
❑Y ❑N Diabetes
❑Y ❑N Epilepsy
❑Y ❑N Fainting
❑Y ❑N Glaucoma
❑Y ❑N Headaches
❑Y ❑N Heart murmur
❑Y ❑N Heart problems
Describe _____
❑Y ❑N Hemophilia
❑Y ❑N Abnormal bleeding
❑Y ❑N Herpes
❑Y ❑N Hepatitis

❑Y ❑N High blood pressure
❑Y ❑N Jaw pain
❑Y ❑N Kidney disease or malfunction
❑Y ❑N Liver disease
❑Y ❑N Material allergies (**latex**, wool, metal, chemicals)
❑Y ❑N Mitral valve prolapse
❑Y ❑N Nervous problems
❑Y ❑N Pacemaker/ Heart surgery
❑Y ❑N Psychiatric care
❑Y ❑N Rapid weight gain or loss
❑Y ❑N Radiation treatment
❑Y ❑N Respiratory disease

❑Y ❑N Rheumatic/Scarlet fever
❑Y ❑N Shingles
❑Y ❑N Shortness of breath
❑Y ❑N Skin rash
❑Y ❑N Stroke
❑Y ❑N Surgical implant
❑Y ❑N Swelling of feet or ankles
❑Y ❑N Thyroid disease or malfunction
❑Y ❑N Tobacco habit
❑Y ❑N Tonsillitis
❑Y ❑N Tuberculosis
❑Y ❑N Ulcer/Colitis
❑Y ❑N Venereal disease

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 to 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.

I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

Signature_____ Date _____

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

POS Reorder # 1524502