

# Graham L. W. Simpson, D.D.S.

## Aesthetic Prosthodontic Dentistry

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### PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
Last First Middle Street City State Zip Code

Home Ph. #: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_ Cell Ph. #: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Name of Nearest Relative Not Living With You: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Ph. #: \_\_\_\_\_

**In Case of Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Ph. #:** \_\_\_\_\_ **Cell Ph. #:** \_\_\_\_\_ **Work Ph. #** \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Ph. #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Spouse or Domestic Partner: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### INSURANCE

Insured's Name: \_\_\_\_\_ Insured Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Ph. #: \_\_\_\_\_

### DENTAL INFORMATION

Date of Last Dental Exam: \_\_\_\_\_ Last X-Rays: \_\_\_\_\_ Last Dental Cleaning: \_\_\_\_\_

*Please Circle One:*

Do your gums bleed when you brush or floss:	Y N	Do you have earaches or neck pain?	Y N
Are your teeth sensitive to cold, hot sweets or pressure?	Y N	Do you have any clicking, popping or jaw discomfort?	Y N
Does food or floss catch between your teeth?	Y N	Do you brux or grind your teeth?	Y N
Is your mouth dry?	Y N	Do you have sores or ulcers in your mouth?	Y N
Have you had any periodontal (gum) treatments?	Y N	Do you wear dentures or partials?	Y N
Have you had any orthodontic (braces) treatment?	Y N	Have you ever had any serious injury to your head or your mouth?	Y N
Have you had any problems associated with previous dental treatment?	Y N	Do you gag easily?	Y N
Are you currently experiencing dental pain or discomfort?	Y N	Do you have a fear of dental work?	Y N

Do you have or had any condition or problem not listed above? **YES** **NO** (If **YES** please explain:)

Is there anything about your smile that you would like to change? **YES** **NO** (If **YES** please explain:)

### CONSENT

1. The undersigned hereby authorizes Graham L.W. Simpson, D.D.S. to order x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by Graham L.W. Simpson, D.D.S. to make a thorough diagnosis of the patient's dental needs.
2. I also authorize Graham L.W. Simpson, D.D.S. to perform all recommended treatment mutually agreed up by me and to use the appropriate medication and therapy indication for such treatment in connection with (name of patient) \_\_\_\_\_  
I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent Graham L.W. Simpson, D.D.S. to choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I understand that a 1- ½% finance charge (18% APR) may be added to my account, in addition to any collection charge.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent or Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_ Signature: \_\_\_\_\_

**MEDICAL INFORMATION** Please circle one:

Do you use controlled substances (drugs?) **Y N** Are you taking, or scheduled to begin taking  
 Do you use tobacco (smoking, snuff, chew?) **Y N** alendronate (Fosamax®) or risedronate (Actonel®)  
 If so, how interested are you in stopping? for osteoporosis or Paget's disease? **Y N**  
 Circle one: **Very / Somewhat / Not Interested** Do you wear contact lenses? **Y N**

**HAVE YOU EVER HAD ANY OF THE FOLLOWING** Please circle one:

Abnormal bleeding	<b>Y N</b>	Anemia	<b>Y N</b>	Rheumatic heart disease	<b>Y N</b>
Mitral valve prolapse	<b>Y N</b>	Pacemaker	<b>Y N</b>	Rheumatic fever	<b>Y N</b>
Cardiovascular disease	<b>Y N</b>	Hemophilia	<b>Y N</b>	Hepatitis, jaundice or	
Angina	<b>Y N</b>	AIDS or HIV infection	<b>Y N</b>	liver disease	<b>Y N</b>
Arteriosclerosis	<b>Y N</b>	Arthritis	<b>Y N</b>	Epilepsy	<b>Y N</b>
Congestive heart failure	<b>Y N</b>	Autoimmune disease	<b>Y N</b>	Fainting spells	<b>Y N</b>
Damaged heart valves	<b>Y N</b>	Rheumatoid arthritis	<b>Y N</b>	Seizures	<b>Y N</b>
Heart attack	<b>Y N</b>	Systemic lupus erythematosus	<b>Y N</b>	Neurological disorders	<b>Y N</b>
Heart murmur	<b>Y N</b>	Asthma	<b>Y N</b>	Specify : _____	
Low blood pressure	<b>Y N</b>	Bronchitis	<b>Y N</b>	Sleep disorder	<b>Y N</b>
High blood pressure	<b>Y N</b>	Emphysema	<b>Y N</b>	Recurrent infections	<b>Y N</b>
Other congenital heart defects	<b>Y N</b>	Tuberculosis	<b>Y N</b>	Blood transfusion	<b>Y N</b>
Emphysema	<b>Y N</b>	Cancer	<b>Y N</b>	Kidney problems	<b>Y N</b>
Chest pain upon exertion	<b>Y N</b>	Chemotherapy / Radiation	<b>Y N</b>	Night sweats	<b>Y N</b>
Chronic pain	<b>Y N</b>	Diabetes Type: I or II	<b>Y N</b>	Osteoporosis	<b>Y N</b>
Eating disorder	<b>Y N</b>	Malnutrition	<b>Y N</b>	Persistent swollen glands	
Gastrointestinal disease	<b>Y N</b>	G.E. reflux / persistent heartburn	<b>Y N</b>	in neck	<b>Y N</b>
Ulcers	<b>Y N</b>	Thyroid problems	<b>Y N</b>	Severe headaches	
Stroke	<b>Y N</b>	Glaucoma	<b>Y N</b>	or migraine	<b>Y N</b>
Excessive urination	<b>Y N</b>	Sexually transmitted disease	<b>Y N</b>	Severe or rapid weight loss	<b>Y N</b>
Active tuberculosis	<b>Y N</b>	Persistent cough greater than 3 weeks duration	<b>Y N</b>		
Cough that produces blood	<b>Y N</b>	Been exposed to anyone with tuberculosis	<b>Y N</b>		

**ALLERGIES** Are you allergic to, or had a reaction to any of the following:

Local Anesthetics	<b>Y N</b>	Barbiturates, sedatives,		Latex (rubber)	<b>Y N</b>
Aspirin	<b>Y N</b>	or sleeping pills	<b>Y N</b>	Iodine	<b>Y N</b>
Penicillin or Antibiotics	<b>Y N</b>	Codeine or other narcotics	<b>Y N</b>	Hay fever/seasonal	<b>Y N</b>
Sulfa Drugs	<b>Y N</b>	Metals	<b>Y N</b>	Other _____	

Artificial (prosthetic) heart valve	<b>Y N</b>
Previous infective endocarditis	<b>Y N</b>
Damaged valves in transplanted heart	<b>Y N</b>
Congenital heart disease (CHD)	<b>Y N</b>
Un-repaired, cyanotic CHD	<b>Y N</b>
Repaired (completely) in last 6 months	<b>Y N</b>
Repaired CHD with residual defects	<b>Y N</b>

**WOMEN ONLY**

Pregnant? **Y N**

Number of Weeks: \_\_\_\_\_

Nursing? **Y N**

Taking birth control pills or hormonal replacement? **Y N**

**PLEASE LIST ALL CURRENT MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE LIST ALL VITAMINS, NATURAL HERBAL PERPARATIONS AND / OR SUPPLEMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who may thank for referring you to our office: \_\_\_\_\_

Who is your General Dentist: \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient or Guardian's Signature: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_