Rebecca Armel D.D.S. Inc.
490 Post St. Suite 1690 San Francisco, CA 94102 (415)-421-0317

Patient Health Record

In order to provide the appropriate dental care, please fill out the following questionnaire. Thank You.

Name _____
Last First Middle

Residence Address _____

Home Phone Cell Phone Email

Birthdate Sex Height Weight Marital Status

Insurance carrier Phone #

Insurance group number **or** Social security #

Occupation Employer name

Employers address

Name of Spouse Bithdate

Spouse's insurance carrier policy / group number

Referred by most convenient appointment time

How do you prefer to be contacted? Email or phone?

Authorization to release records and assignment of benefits

I, the undersigned patient and/ or insured, in requesting examination and treatment on myself or my dependants on or after this date, authorize the release of all the information relative to said examination and treatment to any health service plan or insurance company, I designate to Rebecca Armel DDS Inc.
I hereby authorize payment directly to Rebecca Armel DDS Inc. of the group benefits otherwise payable to me.
I realize that the total fee for professional services is my responsibility, regardless of what benefits I do or do not receive from my insurance company.

Patient's Signature Date

Parent or guardian's signature Date

Dental History

please circle

Do you have a specific dental problem? Describe _____ yes / no
Do you see the dentist regularly? Last visit _____ yes / no
Do you think you have active decay or gum disease? _____ yes / no
Do you brush and floss regularly? How many times a day? _____ yes / no
Do your gums ever bleed ? _____ yes / no
Do you catch food between teeth? _____ yes / no
Do you have pain in your jaw joint? Do you grind? _____ yes / no

Do you like your smile? _____ yes / no

Do you chew or smoke tobacco? _____ yes / no

Have your past dental experiences been positive? _____ yes / no

Name of previous dentist? _____

Medical History

Are you under a physician's care now? Why? _____
Doctor's name & phone number _____
Have you ever been hospitalized or had major surgery? _____
Are you taking any medications? _____
Are you allergic to any medications? _____
Women Are you pregnant? Nursing? Taking BCP? _____

Have you had any of the following? Please circle any that you have had.

Heart trouble/ Disease	Ulcers	Emphysema	Kidney problems	Cold sores
Heart murmur	Anemia	Cancer	Thyroid problems	Sinus trouble
Mitral Valve prolapse	Diabetes	Arthritis	Intestinal problems	Stroke
Pacemaker	Asthma	Allergies	Liver disease	Epilepsy
High Blood pressure	HIV positive	Glaucoma	Drug addiction/ Alcoholism	Fainting or dizziness
Artificial Joint	Hepatitis A	Hepatitis B/C	Radiation treatment	Psychiatric care
Artificial Heart valve	Lung disease	Hemophilia	Blood Transfusions	Low blood pressure

Have you had any other serious illness not mentioned above? _____ yes/ no

Please discuss _____

To the best of my knowledge all the preceding answers are correct. If I have any medical changes I will inform Dr. Armel

Patient Signature (Guardian) x _____ **Date** _____

Reviewed by Doctor _____ Date _____

History review and significant findings: _____ BP _____

Medical updates

Date	Changes	Doctor's signature