Welcome to Bella Smiles

The Dental Office of Jaime Rojas, DDS
78640 Highway 111
La Quinta, CA 92253
Phone: (760)564-0955

Patient Information…

Today's Date: _____

Patient Name: _____ ☐ Male ☐ Female
Last First MI

What You Prefer To Be Called: _____ Birth Date: ___/___/_____ Age: _____ SS#: _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

E-mail Address: _____ Referred By: _____

Employer: _____ Occupation _____ How Long? _____

Employer's Address: _____ City _____ State _____ Zip _____

Status: ☐ Single ☐ Married ☐ Minor ☐ Other **Spouse/Parent/Guardian Name:** _____

In Case of Emergency, Please Contact: _____ Relation: _____

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Who Will Be Responsible For Your Account: _____ **Relation:** _____

Address: _____ Phone: _____

Primary Dental Insurance

Subscriber Name: _____

Relation _____ D.O.B. _____

Employer: _____

Address: _____

City _____ State ___ Zip _____

Insurance Co. _____

Address _____

City/State/Zip _____

Phone # (___) _____

ID or SS # _____ Group# _____

Secondary Dental Insurance

Subscriber Name: _____

Relation _____ D.O.B. _____

Employer: _____

Address: _____

City _____ State ___ Zip _____

Insurance Co. _____

Address _____

City/State/Zip _____

Phone # (___) _____

ID or SS # _____ Group# _____

Dental Information

Reason for today's visit?_____ Are you in pain? ❑Yes❑No How long?_____

Please indicate any of the following problems, conditions, or treatment by checking off the corresponding box:

Y or N Discomfort, clicking, or popping in jaw
Y or N Teeth grinding
Y or N Clenching
Y or N Difficulty closing or opening jaw
Y or N Locking jaw
Y or N Ringing in ears
Y or N Lost /broken filling(s)
Y or N Broken/chipped tooth

Y or N Loose/shifting teeth
Y or N Food caught between teeth
Y or N Toothache
Y or N Stained teeth
Y or N Red, swollen, or bleeding gums
Y or N Blisters/sores in or around the mouth

Y or N Swelling/lumps in mouth
Y or N Burning tongue/lips
Y or N Bad breath
Y or N Gum Disease
Y or N Orthodontics
Y or N A removable dental appliance

Y or N Sensitive teeth:
❑Hot❑Cold
❑ Sweets❑ Biting
Y or N Jaw Problems: TMJ/TMD
Y or N Snoring/Sleep Problems
Y or N Do you use a CPAP
❑Other _____
_____

Last dental exam: _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristle do you use?❑ Soft❑ Medium❑ Hard Previous Dentist:_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Phone# (_____)_____

Medical History

Physician's Name:_____ **Phone**: _____

Address:_____ Date of last visit:_____

Are you currently under the care of a physician? **Y or N** If yes, for what?_____

Do you have any medical conditions that require antibiotic pre-medication prior to receiving dental treatment?❑ Yes ❑ No

Do you use tobacco?❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y or N Heart Attack
Y or N Heart Surgery_____
Y or N Pacemaker
Y or N Heart Murmur
Y or N Mitral Valve Prolapse
Y or N Stroke
Y or N Artificial Valves
Y or N Rheumatic Fever
Y or N Chest Pains/Angina
Y or N High Blood Pressure
Y or N Low Blood Pressure
Y or N Congenital Heart Defect
Y or N Scarlet Fever

Y or N Diabetes
Y or N Hypoglycemia
Y or N Anemia
Y or N Thyroid Problems
Y or N Kidney Problems
Y or N Dialysis
Y or N Asthma
Y or N Respiratory Problems
Y or N Emphysema
Y or N Stomach Problems/Ulcers
Y or N Sinus Problems
Y or N Tuberculosis
Y or N Nervousness

Y or N Psychiatric Problems
Y or N Venereal Disease/STD
Y or N Herpetic Lesions
Y or N Alcohol Abuse
Y or N Drug Abuse
Y or N Hepatitis _____
Y or N HIV+/AIDS/ARC
Y or N Shingles
Y or N Cancer, type:_____
Y or N Tumor or Growth
Y or N Radiation/Chemotherapy/ Cobalt Treatment
Y or N Fainting

Y or N Seizures/Epilepsy
Y or N Severe/Frequent Headaches
Y or N Arthritis/Rheumatism
Y or N Artificial Bones/Joints
Type/year _____
Y or N Cosmetic Surgery
Y or N Frequent Neck Pain
Y or N Back Problems
Y or N Bleeding Problems
Y or N Glaucoma
Y or N Contact Lenses

Please list any other surgeries or medical conditions you have or ever had:_____

_____

For Women: Are you pregnant❑No ❑Yes/How long_____ Are you nursing?❑ Yes❑ No Are you taking birth control pills?❑ Yes ❑ No How many children have you had?_____

Pharmacy:_____ **Phone:** _____

What medications are you currently taking?

Y or N Blood Thinners _____
Y or N Pain Killers (including aspirin):
_____
Y or N Nerve Pills
Y or N Muscle Relaxers _____
Y or N Stimulants

Y or N Antidepressants _____
Y or N Insulin
Y or N Tranquilizers
Y or N Diet Pills
Y or N Are you now taking or have you ever taken any Bisphosphonate

Medication: (Aredia, Zometa, Fosamax, Actonel, or Boniva)
Y or N Other(s): _____
_____
_____

Are you allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Aspirin ☐ Codeine ☐ Sulfa drugs
☐ Dental Anesthetics ☐ Foods _____ Other: _____

- I understand the above information, and guarantee this was completed to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have been given the opportunity to review the Financial Policy for the Office of Jaime Rojas, DDS, Inc (a copy of this policy will be given upon request). Our policy requires payment in full for all services rendered at the time of visit.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☒ _____ ☐ Adult Patient ☐ Parent/Guardian **Date** _____

Pain & Sedative Medication Disclosure Form

For the health & well being of all our patients, we are implementing a new policy. Before Dr. Rojas prescribes any pain & sedative medications for you, we ask that you disclose to us all *pain & sedative medications that you are currently taking that have been prescribed for you by another doctor.*

Medication/Strength	Quantity	Directions	Medical Condition

_____ _____
Patient Signature Date