

R.K. Chetty D.D.S., Inc.

2525 Colorado Blvd. Suite A
Los Angeles, Ca 90041
(323) 258-2885

Welcome to our office! We will always strive to provide you with the best possible dental care. To help us meet all of your dental needs, please fill out this form completely. If you have any questions or concerns, please ask us...we will be happy to help!

Today's Date: _____

Patient Information

Name _____	Birthdate _____	Soc. Sec.# _____
Address _____	City _____	Zip _____
Phone _____		
Please check one: Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>		
Name of School / College (If Student) _____		
Whom May We Thank for Referring You? _____		
Person to Contact in Case of Emergency _____		Phone _____
Relationship to Patient _____		

Responsible Party

Name of Person Responsible for this Account _____		
Address _____	City _____	Zip _____
Phone _____	Soc. Sec.# _____	
Relationship to Patient _____	Birthdate _____	Drivers License _____
Employer _____	Date Employed _____	Phone _____
Address _____	City _____	Zip _____
Is this Person Currently a Patient in our Office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, complete the following:

Insurance Information

Primary Insurance _____	Group # _____	Union or Local _____
Address _____	City _____	Zip _____
Secondary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete the following:	
Name of Insured _____		
Address _____	City _____	Zip _____
Relationship to Patient _____	Birthdate _____	Drivers License _____
Employer _____	Date Employed _____	Phone _____
Address _____	City _____	Zip _____
Insurance _____	Group # _____	Union or Local _____
Address _____	City _____	Zip _____

(Over)

Patient Medical History

Physician _____ Phone _____ Date of Last Exam _____

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| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you taking any medication(s) including any non-prescription medicine? If yes, which medication(s) are you taking? _____</p> <p>4. Do you tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you using, or used in the past any illegal drugs such as cocaine, marajuana, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you taking or have taken in the past the diet control tablets, Phen-Fen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>9. Are you allergic to or have you had any reactions to the following?</p> <p>Local Anesthetics (i.e. Novocaine) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, which one(s) _____</p> <p>Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Women Only</p> <p>Are you pregnant or think you may be? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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Do you have or have had any of the following?

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| <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problem <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cardiac Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis / Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Troubles or Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any other problems not mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please explain</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
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Patient Dental History

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| <p>1) Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2) Are your teeth sensitive to hot or cold liquids / foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3) Are your teeth sensitive to sweet or sour liquids / foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4) Do you feel pain in any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5) Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6) Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7) Have you experienced any of the following problems in your jaw?</p> <p>a) Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) Difficulty in opening and / or closing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>d) Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8) Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9) Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10) Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11) Have you ever had difficult extractions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12) Have you had any orthodontic work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13) Have you ever had any prolonged bleeding after extraction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14) Have you ever had instructions on the correct a) method of brushing your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15) Have you ever had instructions on the care of your gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Dr. Chetty to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's (or Guardian's) Signature _____ Date _____

Doctor's Signature _____		Date _____			
Health History Update					
Date	Patient's Signature	Doctor's Signature	Date	Patient's Signature	Doctor's Signature
Comments:					