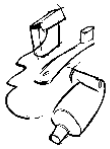


Agnes S. Yumiaco, DMD, Inc.
947 Enterprise Drive, Suite H
Sacramento, CA 95825
(916) 929-0248

Patient Questionnaire

We would like to take this opportunity to welcome you and thank you for selecting our office. So that we may provide you with quality care, please fill out this form completely.

Information you give us is confidential and will not be released to anyone without your written consent.

Name: _____ Date of Birth: ____/____/_____ Age: _____ Sex:_____

If a minor, Parent (s) Name: _____ School Attending: _____

Home Address: _____

City/State: _____ Zip: _____Phone: _____ E-Mail: _____

Employer: _____ Occupation: _____ Cell Phone:_____

Work Address: _____ City: _____ Zip: _____ Work Phone: _____

Preferred Method of Contact: (Please Circle) **E-Mail Text Message Home Phone Cell Phone Work Phone**

Your I.D. #:_____ Your Driver's License #:_____

Spouse's Name_____ Spouse's Employer: _____

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

In case of emergency, who should be notified? _____

Relationship to you: _____ Phone:_____

Person financially responsible: _____ Relationship to you:_____

Reason for appointment: _____

Who may we thank for referring you? _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured:_____	
Date of Birth:_____ I.D. #:_____	Name of Insured:_____
Name of Employer:_____	Date of Birth:_____ I.D. #:_____
Name of Dental Plan:_____	Name of Employer:_____
Group #:_____ Union Local #_____	Name of Dental Plan:_____
	Group #:_____ Union Local #_____

INSURANCE RELEASE: AUTHORIZATION TO PAY AND TO RELEASE INFORMATION: I hereby authorize insurance benefit payments directly to Dr. A. Yumiaco for her services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original. I also authorize Dr. A. Yumiaco to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim. I consent to photography, filming, recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications provided my identity is not revealed. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs.
FINANCIAL RESPONSIBILITY: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.
NOTE: For appointments that are failed or cancelled less than 48 hours in advance, there will be a $25.00 per hour fee charged for the total appointment time that was scheduled.

Patient Signature/Parent or Guardian Signature:_____
Date:_____/_____/_____

Agnes S. Yumiaco, DMD, Inc.
947 Enterprise Drive, Suite H
Sacramento, CA 95825
(916) 929-0248

MEDICAL HISTORY

Name_____ Date:_____/_____/_____

Although dental personnel primarily treat the area on and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Physician's Name:_____ _____ Kaiser #_____

Physician's Address:_____ ___ City:_____ _____ Zip:_____ Phone:_____ ____

Are you now under a physician's care? _____

Have you ever been hospitalized or had a serious illness within the past year?_____

If yes, please explain:_____

******Please list all medications you are taking DAILY-PRESCRIPTION and NON-PRESCRIPTION below******

_____

_____

1. **Do you have an Artificial Heart Valve? _____**
   What Pre-Med antibiotic do you take? _____
2. **Do you have any Artificial Joints? (Hip, Knee) _____**
   What Pre-Med antibiotic do you take? _____
3. **Have you ever taken Phen-Fen or Redux? _____**
4. **Do you smoke? If yes, how much? _____**
5. **Do you have any disease, condition or problem not listed above that you think we should know about? If yes, please explain:_____**
6. **Have there been complications with any dental treatment?**
   If so, please explain:_____
7. **Have you ever taken any Bisphosphonates (Fosamax, Actonel, Boniva, IV Aredia, IV Zometa)? _____**

****

FOR WOMEN ONLY: Are you pregnant? If yes, what month?_____

ARE YOU ALLERGIC OR HAVE REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

(Please put a check mark on your answer)

1. Aspirin…….☐ YES ☐ NO	9. Nitrous Oxide…….……☐ YES ☐ NO
2. Tetracycline……..☐ YES ☐ NO	10. Codeine…….……☐ YES ☐ NO
3. Sulfa Drug…….……☐ YES ☐ NO	11. Percodan…….……☐ YES ☐ NO
4. Erythromycin……☐ YES ☐ NO	12. Valium…….……☐ YES ☐ NO
5. Penicillin……...☐ YES ☐ NO	13. Vicodin…….……☐ YES ☐ NO
6. Other Antibiotics……...☐ YES ☐ NO	14. Latex…….……☐ YES ☐ NO
7. Local Anesthetic……...☐ YES ☐ NO	15. Other: _____
8. Demerol……..☐ YES ☐ NO	

Agnes S. Yumiaco, DMD, Inc.
947 Enterprise Drive, Suite H
Sacramento, CA 95825
(916) 929-0248

Have you ever had: (Please put a check mark on your answer)

1. **High Blood Pressure……☐ YES ☐ NO**	20. **Arthritis……☐ YES ☐ NO**
2. **Angina Pectoris ……☐ YES ☐ NO**	21. **Epilepsy ……☐ YES ☐ NO**
3. **Heart Attack / Stroke …… ☐ YES ☐ NO**	22. **Diabetes (sugar in blood) ……☐ YES ☐ NO**
4. **Heart Surgery ……☐ YES ☐ NO**	23. **Glaucoma……☐ YES ☐ NO**
5. **Pacemaker ……☐ YES ☐ NO**	24. **Ulcers……☐ YES ☐ NO**
6. **Osteoporosis/Osteopenia ……☐ YES ☐ NO**	25. **Gastrointestinal Disorders……☐ YES ☐ NO**
7. **Rheumatic Fever……☐ YES ☐ NO**	26. **AIDS---HIV Positive……☐ YES ☐ NO**
8. **Sickle Cell Disease……☐ YES ☐ NO**	27. **Fainting or Dizzy Spells……☐ YES ☐ NO**
9. **Venereal Disease……☐ YES ☐ NO**	28. **Nervousness……☐ YES ☐ NO**
10. **Tuberculosis ……☐ YES ☐ NO**	29. **Asthma……☐ YES ☐ NO**
11. **Kidney Disease……☐ YES ☐ NO**	30. **Allergies or Hives ……☐ YES ☐ NO**
12. **Thyroid Disease ……☐ YES ☐ NO**	31. **Sinus Troubles ……☐ YES ☐ NO**
13. **Jaundice (yellow eyes, skin)…… . …..☐ YES ☐ NO**	32. **Hay Fever ……☐ YES ☐ NO**
14. **Hepatitis A, B, or C……☐ YES ☐ NO**	33. **Allergy to Metals (nickel)……☐ YES ☐ NO**
15. **Liver Disease……☐ YES ☐ NO**	34. **Skin reaction to jewelry……☐ YES ☐ NO**
16. **Blood Transfusions……☐ YES ☐ NO**	35. **Cosmetic Surgery……☐ YES ☐ NO**
17. **Bleeding Problems (ex. Hemophilia) ☐ YES ☐ NO**	36. **Tumors or Growth……☐ YES ☐ NO**
18. **Anemia……☐ YES ☐ NO**	37. **Radiation Treatment (X-Ray or Cobalt)..☐ YES ☐ NO**
19. **Psychiatric Treatment..…. . . ..……☐ YES ☐ NO**	38. **Chemotherapy (Cancer, Leukemia) ……☐ YES ☐ NO**

Patient:_____ Date:_____/_____/_____ Witness:_____

****

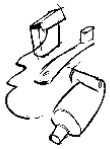
Who do you know that may benefit from our services?

Name: _____ E-mail:_____ Phone: _____

Would they mind if we contacted them? _____

****

Date	Changes/Additions	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Agnes S. Yumiaco, DMD, Inc.
947 Enterprise Drive, Suite H
Sacramento, CA 95825
(916) 929-0248

INITIAL CLINICAL EXAMINATION

DATE: / /

PATIENT NAME	WISHES TO BE CALLED

INITIAL CONCERN _____

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING

1. DO YOU HAVE ANY DENTAL PROBLEMS NOW?..... .....☐ YES ☐ NO

2. DO YOU HAVE TEETH THAT ARE SENSITIVE TO HOT OR COLD?.... ☐ YES ☐ NO

SWEETS?.....☐ YES ☐ NO

3. HAVE YOU EVER HAD:

a. ORTHODONTIC TREATMENT?.....☐ YES ☐ NO

b. ORAL SURGERY?.....☐ YES ☐ NO

c. PERIODONTAL TREATMENT?.....☐ YES ☐ NO

d. YOUR TEETH GROUND OR THE BITE ADJUSTED?.....☐ YES ☐ NO

e. WORN A BITE PLATE OR OTHER APPLIANCE?.....☐ YES ☐ NO

4. HAVE YOU NOTICE ANY LOOSENING OF YOUR TEETH?.....☐ YES ☐ NO

5. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?...☐ YES ☐ NO

6. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS?☐ YES ☐ NO

7. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH?...☐ YES ☐ NO

8. HAVE YOUR PARENTS EXPERIENCED GUM DISEASE? .....☐ YES ☐ NO

9. PROBLEMS OF THE JAW-- HAVE YOU EXPERIENCED:

a. CLICKING OF THE JAW?.....☐ YES ☐ NO

b. PAIN (JOINT, EAR, SIDE OF FACE)?.....☐ YES ☐ NO

c. DIFFICULTY IN OPENING OR CLOSING?.....☐ YES ☐ NO

d. DIFFCULTY IN CHEWING?.....☐ YES ☐ NO

10. HABITS—DO YOU:

a. CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP?.....☐ YES ☐ NO

b. BITE YOUR LIPS OR CHEEKS REGULARLY.....☐ YES ☐ NO

c. HOLD FOREIGN OBJECTS WITH YOUR TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)?.....☐ YES ☐ NO

d. MOUTH BREATHE WHILE AWAKE OR ASLEEP?.....☐ YES ☐ NO

11. DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT?.....☐ YES ☐ NO

12. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE?.....☐ YES ☐ NO

13. DO YOU EXPECT TO EVENTUALLY LOSE YOUR TEETH? .....☐ YES ☐ NO

14. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH?...☐ YES ☐ NO

15. IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT BOTHERS YOU?.....☐ YES ☐ NO
(IF YOU ANSWERED YES, PLEASE LEAVE AN EXPLAINATION BELOW)

_____

_____

_____

_____

_____

_____

_____

Notes: _____

_____

_____

_____

_____