

CANYONVIEW DENTISTRY

Ken Whelan DDS
Cosmetic, Laser & Sleep Dentistry
5475 E La Palma Ave. Suite 110
Anaheim Hills, CA 92807
714-779-8100

Medical History/Registration Form

Preferred Name: _____ Date: _____

Full Name: Mr./ Ms/: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____

Home#: _____ Work#: _____

Primary Email Address _____

Age: _____ Birthdate: ____/____/____ SS# ____/____/____

Emergency Contact: _____

Relationship: _____ Cell # _____

Marital Status: _____

Occupation _____

Employer/School _____ Employer Address _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____ Is patient covered by additional insurance? Yes No

Relationship to Patient _____ Subscriber's Name _____

Insurance Co. _____ Birthdate _____ SS# _____

Group # _____ Relationship to Patient _____

Insurance Co. _____

Group # _____

Dental Insurance Assignment and Release : I certify that I, and/or my dependents(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr.

_____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

XX _____ **Signature of Patient, Parent, Guardian or Personal Representative**

_____ Print name of Patient or Parent Date _____

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Dental History

Reason for today's visit _____

Former Dentist _____ City State _____

Date of last Dental visit _____

Date of last dental x-rays _____ How Often Do You Floss? _____

How Often Do You Brush? _____

Please circle if you have, or have had, any of the following below:

Bad Breath, Bleeding Gums,	Blisters on Lip or Mouth,
Burning Sensation on Tongue,	Periodontal Treatment,
Chew on One Side of Mouth,	Cigarette, Pipe, or Cigar Smoking,
Clicking or Popping Jaw	Dry Mouth, Fingernail Biting, Food
Collection between the Teeth,	Foreign Objects, Grinding Teeth,
Gums Swollen or Tender,	Jaw Pain or Tiredness,
Lip or Cheek Biting,	Loose Teeth or Broken Fillings,
Mouth Breathing, Mouth Pain,	Brushing Pain around Ear,
Orthodontic Treatment,	Sensitivity to Cold , Sensitivity to Heat
Sensitivity to Sweets	Sensitivity When Biting, Sores or Growths in Your Mouth

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any group of drugs collectively referred to as "fen-phen"? _____

Please circle if you have, or have had, any of the following:

Aids/HIV	Anemia	Arthritis/Rheumatism	Artificial Heart Valves
Artificial Joints	Asthma	Back Problems	Cancer
Blood Disease	Chemical Dependency	Chemotherapy	
Circulatory Problems	Congenital Heart Lesions	Cortisone Treatments	
Cough, Persistent/Bloody	Diabetes, Emphysema	Epilepsy, Fainting or Dizziness	
Glaucoma	Frequent Headaches	Heart Murmur Heart Problems	
Hepatitis Type _____	Herpes	High Blood Pressure	Jaundice Kidney Disease
Liver Disease	Low Blood Pressure	Mitral Valve Prolapse	<u>Continue Next Page</u>

