Michael Thylin, DDS

3144 El Camino Real, Suite 203, Carlsbad, CA 92008 ◇ Phone: 760-730-9700

PATIENT INFORMATION

Date: ______________ ID# or SS# ______________________

Patient: ____

Address: ____

____
City State Zip

Sex: ☐ M ☐ F Age: ________ Birthdate: ____________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: ____

Employer: ____

Employer Address: ________________________________

Employer Phone: __________________________________

Spouse's Name: ___________________________________

Birthdate: ________________ SS# __________________

Occupation: ____

Spouse's Employer: ________________________________

Whom m ay we thank for referring you? ______________________

____

DENTAL INSURANCE

Subscriber: ________________________ DOB: ________

Relationship to Patient: ____________________________

Employer: ____

Insurance Co: ______________________ Phone: ________

ID #: ________________ Group #: ______________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber: ________________________ DOB: ________

Relationship to Patient: ____________________________

Employer: ____

Insurance Co: ______________________ Phone: ________

ID #: ________________ Group #: ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with:

______________________________ and assign directly to Michael Thylin, DDS, 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

____
Responsible Party Signature

____
Relationship Date

Contact Information

Home ( ) Work ( ) Cell ( )

Email ______________________________

Best time and place to reach you

Additional Contact (optional): Relationship:

Home Phone: ( ) Work Phone: ( )

DENTAL HISTORY

☐ Y=Yes ☐ N=No

Reason for today's visit? ______________________

____

Former Dentist: ______________________

City / State: ______________________

Date of last dental visit: ______________________

Date of last dental x-rays: ______________________

Check (✓) all of the following that apply...

Bad Breath	☐ Y	☐ N
Bleeding Gums	☐ Y	☐ N
Blisters on lips or mouth	☐ Y	☐ N
Jaw pain or tiredness	☐ Y	☐ N

How often do you floss? ______________

Burning sensation on tongue	☐ Y	☐ N
Chew on one side of mouth	☐ Y	☐ N
Cigarette, pipe, of cigar Smoking	☐ Y	☐ N
Clicking or popping jaw	☐ Y	☐ N
Dry mouth	☐ Y	☐ N
Fingernail biting	☐ Y	☐ N
Food collection between teeth	☐ Y	☐ N
Foreign objects	☐ Y	☐ N
Grinding teeth	☐ Y	☐ N
Gums swollen or tender	☐ Y	☐ N
Lip or cheek biting	☐ Y	☐ N

How often do you brush? ______________

Loose teeth or broken fillings	☐ Y	☐ N
Mouth breathing	☐ Y	☐ N
Mouth pain, brushing	☐ Y	☐ N
Orthodontic treatment	☐ Y	☐ N
Pain around ear	☐ Y	☐ N
Periodontal treatment	☐ Y	☐ N
Teeth sensitive to cold	☐ Y	☐ N
Teeth Sensitive to heat	☐ Y	☐ N
Sensitive to sweets	☐ Y	☐ N
Sensitivity when biting	☐ Y	☐ N
Sores or growths in mouth	☐ Y	☐ N

~ OVER ~

HEALTH HISTORY

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes____ No____

Check (✓) if you have ever had or now have the following: ☐ Y=Yes ☐ N=No

AIDS / HIV	☐ Y	☐ N	Emphysema	☐ Y	☐ N	Radiation Treatment	☐ Y	☐ N
Anemia	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Respiratory Disease	☐ Y	☐ N
Arthritis, Rheumatism	☐ Y	☐ N	Fainting of dizziness	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Artificial Heart Valves	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N
Artificial Joints	☐ Y	☐ N	Headaches/Migraines	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
Asthma	☐ Y	☐ N	Heart Problems or Murmur	☐ Y	☐ N	Sinus Trouble	☐ Y	☐ N
Back Problems	☐ Y	☐ N	Hepatitis Type: __________	☐ Y	☐ N	Skin Rash	☐ Y	☐ N
Bleeds abnormally easy	☐ Y	☐ N	Herpes	☐ Y	☐ N	Special Diet	☐ Y	☐ N
Blood Disease	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Stroke	☐ Y	☐ N
Cancer	☐ Y	☐ N	Jaundice	☐ Y	☐ N	Swelling of Feet or Ankles	☐ Y	☐ N
Chemical Dependency	☐ Y	☐ N	Jaw Pain	☐ Y	☐ N	Swollen Neck Glands	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Kidney Disease	☐ Y	☐ N	Thyroid Problems	☐ Y	☐ N
Circulatory Problems	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Congenital Heart Lesions	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Cortisone Treatments	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N	Tumor / growth on head/neck	☐ Y	☐ N
Cough, Persistent or bloody	☐ Y	☐ N	Nervous Problems	☐ Y	☐ N	Ulcer	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Do you wear contact lenses?	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N	Weight loss, unexplained	☐ Y	☐ N
Acid Reflux/Gerd	☐ Y	☐ N	Immunications up to date	☐ Y	☐ N	HPV	☐ Y	☐ N
Sleep Apnea	☐ Y	☐ N	Bone Density problems	☐ Y	☐ N	Skin Cancer	☐ Y	☐ N
Smoker/Smokeless Tobacco	☐ Y	☐ N						

I usually take antibiotics prior to dental treatment. ☐ Y ☐ N

Have you had Bisphosphonate Therapy: Aledronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zoledronate (Zometa), Etidronate (Didronel) Pamidronate (Aredia) Yes______ No______

I have had major surgery. ☐ Y ☐ N Year: ______________ Type of operation: ______________________________

Women:

Are you pregnant? ☐ Y ☐ N Due date________________ Are you nursing? ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N

MEDICATIONS: List any medications you are currently taking

Medicine:________________ Condition:__________________

Medicine:________________ Condition:__________________

Medicine:________________ Condition:__________________

Medicine:________________ Condition:__________________

Medicine:________________ Condition:__________________

Medicine:________________ Condition:__________________

Vitamins, Suppl., herbals ______________________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex, Metal, Plastics
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other________________

Physicians Name:______________________ Phone: ____________

Pharmacy Name:______________________ Phone: ____________

In the event of an emergency, please contact:

Name: ____ Relationship: __________________ Phone: ____________

Name: ____ Relationship: __________________ Phone: ____________

Initial medical/dental health reviewed by:

Name: ______________________________ Date: __________

Name: ______________________________ Date: __________

Name: ______________________________ Date: __________

X ______________________________
Patient signature

X ______________________________
If patient is under age, parent or guardian signature