Welcome to Our Office

Dr. Andrew G. Mortensen, D.D.S., Inc

HOW DID YOU HEAR ABOUT OUR OFFICE?

Our practice grows by referrals from our dental family . . . whom may we thank for referring you to us for your dental care?

_____

PERSONAL INFORMATION

NAME: ☐ Male ☐ Female Birthdate: Home phone:

Address: City: Zip: Cell phone:

Employer: How Long Occupation:

Address: City: Zip: Work phone:

Drivers Lic. # Email: S.S. #:

Name of Spouse: (responsible party if minor) Birthdate: Work phone:

Employer: Cell phone:

Address: City: Zip: S.S.#:

INSURANCE AND FINANCIAL INFORMATION

Responsible Party: Birthdate:

Insurance Company: Social Security Number:

Address: Phone Number:

Group Number:_____; or Union Local Number_____; or Plan Number: _____

Person to contact at your company about your insurance policy and coverage: _____

IN CASE OF EMERGENCY: Name of 1 Relative and 1 Friend

Name: Relationship:

Address: Res. # Wk. #

Name: Relationship:

Address: Res. # Wk. #

DENTAL INFORMATION

How long has it been since your last dental treatment? _____

Are you in dental discomfort today? _____

Do your gums bleed when brushing or flossing your teeth? _____

Are you sensitive to hot; cold; sweets; pressure? _____

Do you ever clench or grind your teeth? _____

Have you ever had a bad reaction to dental anesthetic? _____

Have you ever had orthodontic (braces) treatment? When? _____

Have you ever been treated by a periodontist (gum specialist)? _____

Is there anything else you would like us to know about your dental health or your previous dental treatment? _____

18837 Brookhurst Street, Suite 109, Fountain Valley CA. 92708 * Phone # (714) 964-4183 * www.mortensendds.com

MEDICAL HISTORY

1) Have you been under the care of a medical doctor during the past two years? _____

2) Have you been a patient in the hospital during the past two years? _____

3) Are you allergic (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? _____

4) Circle any of the following which you have had or have at present: _____

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Failure	☐	☐	Emphysema	☐	☐	AIDS
☐	☐	Heart Disease or Attack	☐	☐	Cough	☐	☐	Hepatitis A
☐	☐	Angina Pectoris	☐	☐	Tuberculosis	☐	☐	Hepatitis B
☐	☐	High Blood Pressure	☐	☐	Asthma (TB)	☐	☐	Hepatitis C
☐	☐	Heart Murmur	☐	☐	Hay Fever	☐	☐	Liver Disease
☐	☐	Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐	Yellow Jaundice
☐	☐	Congenital Heart Lesions	☐	☐	Allergies or Hives	☐	☐	Blood Transfusion
☐	☐	Scarlet Fever	☐	☐	Diabetes	☐	☐	Drug Addiction
☐	☐	Artificial Heart Valve	☐	☐	Thyroid Disease	☐	☐	Hemophilia
☐	☐	MVP (Mitrovalve Prolapse)				☐	☐	Venereal Disease
☐	☐	Heart Pacemaker	☐	☐	X-ray or Cobalt Treatment	☐	☐	Cold Sores
☐	☐	Heart Surgery	☐	☐	Chemotherapy	☐	☐	Genital Herpes
			☐	☐	Arthritis			
☐	☐	Artificial Joint	☐	☐	Rheumatism	☐	☐	Epilepsy or Seizures
☐	☐	Anemia	☐	☐	Cortisone Medicine	☐	☐	Fainting/Dizziness
☐	☐	Stroke	☐	☐	Glaucoma	☐	☐	Nervousness
☐	☐	Kidney Trouble	☐	☐	Pain in Jaw Joints	☐	☐	Psychiatric Treatment
☐	☐	Ulcers				☐	☐	Sickle Cell Disease
☐	☐	Alcoholism				☐	☐	Bruise Easily
						☐	☐	Frequent Headaches

5) Do you have any disease or condition not listed? _____

6) Do you use tobacco? How Much? _____

7) Are you on any special diet? _____

8) Have you ever had a cancer or a tumor? _____

9) WOMEN: Are you pregnant? _____

10) PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING _____

_____

_____

Name and address of physician

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor, or his staff, at the next appointment without fail.

_____ _____ _____

DATE Patient/Guardian Signature DENTIST/HYGIENIST SIGNATURE

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he seems fit. I also understand the use of anesthetic agents embodies a certain risk. 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. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient:_____ Date:_____ Witness:_____

Parent of Responsible Party_____ Relationship to Patient _____