OFFICE _____

CHART # _____

REFERRAL CODE _____

ARCHIE DENTAL GROUP

1978 Stockton Blvd.
Sacramento, CA 95816
916-451-6591

8013 Laguna Blvd., Suite 2
Elk Grove, CA 95758
916-691-6020

☐ PVT ☐ INS ☐ MC ☐ PP ☐ PLAN

PLEASE PRINT

I. PATIENT INFORMATION

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

_____

_____

_____

Please Check	
MALE	❑
FEMALE	❑

Please Check	
MARRIED	❑
SINGLE	❑
DIVORCED	❑
WIDOWED	❑
CHILD	❑

MR MS MRS MISS	LAST NAME	FIRST NAME	MIDDLE NAME

STREET ADDRESS	
CITY	ZIP CODE
HOME PHONE ( )	WORK PHONE ( )
BIRTHDATE (MO/DAY/YEAR)	AGE
PATIENT SOCIAL SECURITY #	
DRIVER'S LICENSE NUMBER	E-MAIL
OCCUPATION	HOW LONG EMPLOYED?
EMPLOYER NAME	
EMPLOYER ADDRESS / CITY / ZIP CODE	

RELATIONSHIP TO PATIENT:

PARENT ❑ LEGAL GUARDIAN ❑

STEP-PARENT ❑ OTHER _____

II. INSURANCE INFORMATION PARENT/RESPONSIBLE PARTY

Please Check	
MALE	❑
FEMALE	❑

INSURED EMPLOYEE (PRIMARY)

MR MS MRS MISS	LAST NAME	FIRST NAME	MIDDLE NAME

SOC SEC # INSURED EMPLOYEE	NAME OF EMPLOYER/COMPANY	
DRIVERS LIC. # INSURED EMPLOYEE	EMPLOYER ADDRESS / CITY / STATE	
INSURANCE CO. CARRIER	EMPLOYEE PHONE ( )	DATE OF HIRE
PLAN/GROUP NUMBER	LOCAL NUMBER	
POLICY/I.D. OR MEDI-CAL ID#	DATE OF BIRTH	

III. DUAL INSURANCE INFORMATION

Please Check	
MALE	❑
FEMALE	❑

INSURED EMPLOYEE (SECONDARY)

MR MS MRS MISS	LAST NAME	FIRST NAME	MIDDLE NAME

SOC SEC # INSURED EMPLOYEE	NAME OF EMPLOYER/COMPANY	
DRIVERS LIC. # INSURED EMPLOYEE	EMPLOYER ADDRESS / CITY / STATE	
INSURANCE CO. CARRIER	EMPLOYEE PHONE ( )	DATE OF HIRE
PLAN/GROUP NUMBER	LOCAL NUMBER	
POLICY/I.D. OR MEDI-CAL ID#	DATE OF BIRTH	

IV. GENERAL HEALTH INFORMATION

1. Are you under a doctor's care at this time? YES NO If yes, please specify _____
   Physican's name and phone number _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine?
3. Are you taking any medication at this time? YES NO If yes, please specify _____
4. (Women) Are you pregnant at this time? YES NO If yes, please specify _____
5. Please check any conditions you now have or have had and indicate if active or passive:

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	AIDS	❑	❑	DIZZY SPELLS	❑	❑	HEART MURMUR	❑	❑	LOW BLOOD PRESSURE
❑	❑	ALLERGIES	❑	❑	EMPHYSEMA	❑	❑	HEART PROBLEMS	❑	❑	LUNG DISEASE
❑	❑	ANEMIA	❑	❑	EPILEPSY	❑	❑	HEPATITIS	❑	❑	RHEUMATIC FEVER
❑	❑	ANGINA	❑	❑	FAINTING	❑	❑	HIGH BLOOD PRESSURE	❑	❑	SINUS TROUBLE
❑	❑	ARTHRITIS	❑	❑	FEN-PHEN	❑	❑	JAUNDICE	❑	❑	STROKE
❑	❑	ASTHMA	❑	❑	FEVER BLISTERS	❑	❑	KIDNEY DISEASE	❑	❑	THYROID PROBLEMS
❑	❑	CANCER	❑	❑	GLAUCOMA	❑	❑	LATEX ALLERGY	❑	❑	TUBERCULOSIS
❑	❑	COLD SORES	❑	❑	HEART ATTACK	❑	❑	LIVER PROBLEMS	❑	❑	VENERAL DISEASE
❑	❑	DIABETES	❑	❑	HEART BYPASS						

V. DENTAL INFORMATION

1. Why are you here today? Check-Up ❑ Cleaning ❑ Toothache ❑ Other _____
2. When did you last visit a dentist? _____ 3. What treatment was performed? _____
4. Was the treatment completed? YES NO 5. Did you have a cleaning? YES NO 6. When were dental x-rays last taken? _____
7. Have you ever had prolonged bleeding? YES NO
8. Have you had any problems with past dental treatment? YES NO If yes, please specify _____
9. Do your gums bleed easily? YES NO 10. Do you feel you have bad breath? YES NO 11. Are your teeth sensitive to cold? YES NO

I have filled out this health questionnaire completely and I have advised you of all medical problems of which I am aware. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist is responsible for my dental treatment. My dental treatment and possible alternatives have been discussed with me. I have been informed of all risks involved with my dental care and anesthesia, including possible blood loss and infection. I hereby consent to the administration of anesthesia and the dental treatments specified by the diagnosing doctor. _____ (initial here)

_____ Signature of Doctor

_____ Signature of Patient

_____ Date

_____ Date

Blood Pressure	Readings	Date	Medications	Dr. Sig.
___/___				
___/___				
___/___				
___/___				

OFFICE _____ CHART # _____

PATIENT NAME _____ ACCT. TYPE _____

MEDICAL INFORMATION _____

CHIEF COMPLAINT _____ COMMENTS _____

ORTHO REFERRAL? YES NO PERIO REFERRAL? YES NO

EXISTING RESTORATIONS			DIAGNOSIS TREATMENT PLANNING			ALTERNATE TREATMENT			PERIO				
DATE		FEE	DATE		FEE	DATE		FEE	DATE				
X-RAY			X-RAY			X-RAY			CLASS I II III IV				
TCS			TCS			TCS							
GT	UL UR LL LR		GT	UL UR LL LR		GT	UL UR LL LR		GT	QUADS DIAGNOSED UL UR LL LR			
PERIO SURG	GING UL UR LL LR		PERIO SURG	UL UR LL LR		PERIO SURG	UL UR LL LR						
PERIO SURG	OSSEO UL UR LL LR		PERIO SURG	UL UR LL LR		PERIO SURG	UL UR LL LR			MOBILITY	POCKET DEPTHS BUCCAL / LINGUAL		
SEALANT	UL UR LL LR		SEALANT	UL UR LL LR		SEALANT	UL UR LL LR				M	C	D
Rx	FLUORIDE		Rx	FLUORIDE		Rx	FLUORIDE						
Rx	ORTHO CONS	N/C	Rx	ORTHO CONS	N/C	Rx	ORTHO CONS	N/C					
1			1			1			1		/	/	/
2			2			2			2		/	/	/
3			3			3			3		/	/	/
4A			4A			4A			4		/	/	/
5B			5B			5B			5		/	/	/
6C			6C			6C			6		/	/	/
7D			7D			7D			7		/	/	/
8E			8E			8E			8		/	/	/
9F			9F			9F			9		/	/	/
10G			10G			10G			10		/	/	/
11H			11H			11H			11		/	/	/
12I			12I			12I			12		/	/	/
13J			13J			13J			13		/	/	/
14			14			14			14		/	/	/
15			15			15			15		/	/	/
16			16			16			16		/	/	/
17			17			17			17		/	/	/
18			18			18			18		/	/	/
19			19			19			19		/	/	/
20K			20K			20K			20		/	/	/
21L			21L			21L			21		/	/	/
22M			22M			22M			22		/	/	/
23N			23N			23N			23		/	/	/
24O			24O			24O			24		/	/	/
25P			25P			25P			25		/	/	/
26Q			26Q			26Q			26		/	/	/
27R			27R			27R			27		/	/	/
28S			28S			28S			28		/	/	/
29T			29T			29T			29		/	/	/
30			30			30			30		/	/	/
31			31			31			31		/	/	/
32			32			32			32		/	/	/
FUD			FUD			FUD							
FLD			FLD			FLD							
TEETH RESTS PUD CLASPS			TEETH RESTS PUD CLASPS			TEETH RESTS PUD CLASPS							
TEETH RESTS PLD CLASPS			TEETH RESTS PLD CLASPS			TEETH RESTS PLD CLASPS							

INFLAMMATION:
GINGIVITIS – GENERALIZED
LOCALIZED

PERIODONTITIS:
GEN SEVERE GEN MOD GEN MILD
GEN SEVERE GEN MOD LOC MILD

CALCULUS:
SUPRAGING HEAVY MOD LIGHT
SUBGINGIVAL HEAVY MOD LIGHT

PLAQUE:
HEAVY MODERATE LIGHT

NOTES:

ORAL HYGIENE INSTRUCTIONS NEEDED:
YES NO

PERIODONTAL/ORAL CANCER CHECK:
DATE WNL/AB. RESULTS

DATE OF PRIOR EXTRACTIONS: