Theresa Villano, DDS Ygnacio Valley Rd, Suite 110 Walnut Creek CA 94598 (925) 937-2273

ADVANCED DENTISTRY
OF WALNUT CREEK

Patient Information

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security (Optional): _____Driver's License _____

Address: _____ City _____State _____Zip _____

Home Phone (___) _____ Cell Phone (___) _____

Work Phone (____) _____ Email _____

Preferred Contact: ☐ Text ☐ Phone ☐ Email

Emergency Contact

Name: _____Phone: (___) _____Relationship: _____

Employer Information

Employer: _____Address: _____

Employer Phone: (___) _____ Occupation: _____ ☐ Full-Time ☐ Part-Time

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Responsible Party (If Different)

Name: _____ DOB _____Phone: (___) _____

Address: _____Relationship: _____

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Dental Insurance

Primary Insurance	**Secondary Insurance**
Insurance Company: _____	Insurance Company: _____
Subscriber Name: _____	Subscriber Name: _____
Relationship: _____	Relationship: _____
Subscriber DOB: _____	Subscriber DOB: _____
Member ID: _____	Member ID: _____
Group Number: _____	Group Number: _____
Employer: _____	Employer: _____

Previous Dentist

Dentist Name: _____ Office: _____

Phone: (___) _____ Date of Last Visit: ____/_____/_____ Date of Last Cleaning: ____/_____/____

Date of Last FMX / Bitewings: _____/_____/_____ Date of Last Panoramic: _____/_____/_____

Dental Implants (If known, implant system):

☐ Nobel Biocare Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:	☐ Straumann Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:	☐ BioHorizons Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:	☐ Zimmer Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:
☐ Hiossen Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:	☐ Implant Direct Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored:	☐ Astra Tech Tooth #: _____ Diam Length: _____ Placement Date: ____ Restored:	☐ Other Tooth #: _____ Diam Length: _____ Placement Date: _____ Restored: _____

Previous implant surgeon

Dentist Name: _____ Office: _____

Phone: (___) _____ Address: _____

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Chief Concern

What brings you in today?:_____

_____

_____

Medical History

Primary Care Physician Name: _____ Phone: (_____) _____

Are you pregnant: ☐ YES ☐ NO **Nursing:** ☐ YES ☐ NO **How far along:** _____**Due Date:** _____

Specialists

Cardiologist Name: _____ Phone: (____) _____

Endocrinologist Name: _____ Phone: (____) _____

Oncologist Name: _____ Phone: (____) _____

Other: _____ Phone: (____) _____

Current Medications & Vitamin Supplements

Name	Doses	MG

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Medical Conditions: Please check ALL that apply.

Heart / Cardiovascular	Respiratory	Endocrine	Neurological	Musculoskeletal
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur ☐ Angina ☐ Congestive Heart Failure ☐ Irregular Heartbeat ☐ Pacemaker ☐ Defibrillator ☐ Artificial Heart Valve ☐ Coronary Stents ☐ Rheumatic Fever	☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis ☐ Sleep Apnea ☐ Chronic Bronchitis ☐ Snoring ☐ Sinus Problems	☐ Diabetes Type I ☐ Diabetes Type II ☐ Thyroid Disease ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Adrenal Disorder	☐ Stroke ☐ Seizures ☐ Epilepsy ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Migraines ☐ Dementia	☐ Osteoporosis ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Artificial Joint Joint Replacement Date: _____ Joint Replaced:_____
Blood Disorders	**Infectious Diseases**	**Cancer History**	**Autoimmune**	**Mental Health**
☐ Anemia ☐ Hemophilia ☐ Bleeding Disorder ☐ Easy Bruising ☐ Blood Clot History	☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ HIV/AIDS ☐ MRSA ☐ Tuberculosis ☐Infectious Mononucleosis	☐ Cancer Type _____ Radiation Therapy? ☐ Yes ☐ No Chemotherapy? ☐ Yes Bisphosphonate Therapy? ☐ Fosamax ☐ Prolia ☐ Reclast ☐ Zometa ☐ Other _____ ☐ No	☐ Lupus ☐ Sjögren's Syndrome ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Celiac Disease	☐ Anxiety ☐ Depression ☐ PTSD ☐ Bipolar Disorder ☐ ADHD
Other	☐ Kidney Disease	☐ GERD / Acid Reflux	☐ Breastfeeding	☐ Other

	☐ Liver Disease	☐ Glaucoma ☐ Pregnancy	☐ Latex Sensitivity	

Allergies: Please check all that apply.

Medications	Dental Materials	Other Allergies
☐ Penicillin ☐ Amoxicillin ☐ Clindamycin	☐ Latex ☐ Nickel	☐ Iodine
☐ Sulfa Drugs ☐ Tetracycline ☐ Azithromycin	☐ Acrylic ☐ Metals	☐ Shellfish
☐ Erythromycin ☐ Ciprofloxacin ☐ Codeine	☐ Composite Resin	☐ Adhesives
☐ Hydrocodone ☐ Oxycodone ☐ Morphine	☐ Eugenol ☐ Fluoride	☐ Bee Stings
☐ Tramadol ☐ Aspirin ☐ Ibuprofen	☐ Chlorhexidine	☐ Seasonal Allergies
☐ Naproxen ☐ Acetaminophen		☐ Food Allergies

Specify: _____

Reaction: _____

Lifestyle

Do you smoke? ☐ Never ☐ Former ☐ Current

Vape? ☐ Yes ☐ No

Marijuana? ☐ Medical ☐ Recreational ☐ None

Alcohol ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Patient Goals What is most important to you?

☐ Stay out of pain ☐ Prevent future problems ☐ Improve my smile ☐ Replace missing teeth

☐ Affordable treatment ☐ Maximize insurance ☐ Complete treatment quickly ☐ Cosmetic dentistry

☐ Overcome dental anxiety Other: _____

Consent for Dental Treatment

I authorize Advanced Dentistry of Walnut Creek and its dental professionals to perform examinations, diagnostic procedures, X-rays, cleanings, and other dental treatment that may be recommended and explained to me. I understand that no specific outcome can be guaranteed and that I may ask questions before treatment begins.

Privacy Acknowledgment

I acknowledge that I have been offered or provided access to the dental office's Notice of Privacy Practices. I understand that my protected health information may be used or disclosed for treatment, payment, and health care operations as permitted by applicable law.

Financial Responsibility

I understand that I am responsible for charges not covered by insurance, including deductibles, copayments, denied claims, and services not included in my plan. I authorize the dental office to submit insurance claims on my behalf when applicable.

Patient/Guardian Certification and Signature

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I agree to notify the dental office of any changes to my health, medications, insurance, or contact information.

Patient/Guardian Signature: _____	**Date:** _____
Printed Name: _____	**Relationship to Patient, if applicable:** _____

Office Use Only

Insurance Verified ☐ Yes Eligibility Date _____

FMX Needed ☐ Yes ☐ No

Pre-Authorization Needed ☐ Yes ☐ No

Medical Clearance Needed ☐ Yes ☐ No

Records Requested

☐ Previous X-rays

☐ Periodontal Charting

☐ Treatment Notes

☐ Implant Records

☐ Implant Brand Information

☐ Implant Placement Report

☐ CBCT

☐ Intraoral Photos

☐ Laboratory Information: _____

☐ Warranty Information

Implants: _____

Crowns: _____