ROBERT B. WATKINS, DDS
PROSTHODONTICS &
RESTORATIVE DENTISTRY
2320 Woolsey Street, #112
Berkeley, California 94705
(510)845-1505

Name _____

Birth Date _____ Social Security No. _____

Home Telephone _____ Business Telephone _____

E-mail Address_____

Address _____

City and Zip Code _____

Occupation_____

Business Address_____

Spouse's Name _____

Emergency Contact and Phone _____

If full time student, school _____

Whom may we thank for referring you to our office? _____

FINANCIAL INFORMATION

Person responsible for your account _____

California Drivers License_____

Address _____

Home Telephone _____ Business Telephone _____

Employer Name and Address _____

_____

DENTAL INSURANCE INFORMATION

Name of Employee _____

Employee's Social Security _____

Employee Birth Date _____

Name of Employer _____

Group/Policy Number _____

Insurance Carrier Name _____

Insurance Address _____Insurance Telephone_____

If you have secondary <u>dental</u> coverage, please add this information:

Name of Employee _____

Employee's Social Security _____

Employee Birth Date _____

Name of Employer _____

Group/Policy Number _____

Insurance Carrier Name _____

Insurance Address _____Insurance Telephone_____

MEDICAL INFORMATION AND HISTORY

Physician _____
Address_____
Telephone _____
Is your general health ☐ Good ☐ Fair ☐ Poor
Under current medical care? _____
Date of last medical examination _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY

Heart disease
☐ Yes ☐ No Ischemia/Angina
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Hi/Lo blood pressure
☐ Yes ☐ No Stroke
☐ Yes ☐ No Mitral valve prolapse

Immune Problems
☐ Yes ☐ No Organ transplant
☐ Yes ☐ No Blood transfusion
☐ Yes ☐ No Radiation therapy
☐ Yes ☐ No Artificial hip prosthesis
☐ Yes ☐ No Rashes/hives
☐ Yes ☐ No Tumor/malignancies
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Venereal disease
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Oral herpes

Blood Disorders
☐ Yes ☐ No Kidney disease
☐ Yes ☐ No Excessive bleeding
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Liver disease
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Anemia
☐ Yes ☐ No Blood transfusions

Neurologic
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting
☐ Yes ☐ No Convulsions
☐ Yes ☐ No Nervous/emotional disorders
☐ Yes ☐ No Visual disturbance
☐ Yes ☐ No Migraines
☐ Yes ☐ No Frequent headaches
☐ Yes ☐ No Ear/hearing problem
☐ Yes ☐ No Speech difficulty

Surgery
☐ Yes ☐ No Heart valve implant
☐ Yes ☐ No Heart surgery
☐ Yes ☐ No Joint replacement surgery
☐ Yes ☐ No Heart pacemaker
☐ Yes ☐ No Other surgery _____

Respiratory/Pulmonary
☐ Yes ☐ No Asthma
☐ Yes ☐ No Breathing difficulty
☐ Yes ☐ No Persistent cough
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Obstruction of breath
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Smoke? How much____

Allergies
☐ Yes ☐ No Antibiotics: __penicillin __sulfa __erythromycin __tetracycline
☐ Yes ☐ No Anesthetics: __novocaine __lidocaine __epinephrine
☐ Yes ☐ No Metals: __nickel __gold __alloys __silver __jewelry
☐ Yes ☐ No Analgesics: __aspirin __codeine __narcotics
☐ Yes ☐ No Food groups: __shellfish __milk products __citrus

Do you need antibiotic premedication for dental treatment?
☐ Yes ☐ No

Have you ever taken Phen-Fen?
☐ Yes ☐ No

Please list any prescription or nonprescription medications you currently or occasionally are taking:

_____

_____

Please briefly describe any other medical conditions we should be aware of: _____

_____

_____

DENTAL INFORMATION AND BACKGROUND

Previous Dentist _____Current Dentist_____
Phone _____
Most recent treatment _____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD

☐ Yes ☐ No Endodontics (root canal)
☐ Yes ☐ No Orthodontics (braces)
☐ Yes ☐ No Oral surgery (extractions/operations)
☐ Yes ☐ No Injury to face/jaw
☐ Yes ☐ No Periodontics (gum treatment)
☐ Yes ☐ No TMJ (jaw joint problems)
☐ Yes ☐ No Night guard or occlusal guard
☐ Yes ☐ No Unusual reaction to dental anesthesia
☐ Yes ☐ No Excessive bleeding with dental treatment
☐ Yes ☐ No Other special dentistry or complications:

Date	Patient Signature	Reviewed By Dr.