

# Allan P. Capinpin, D.D.S.

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Gender  Male  Female

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Single  \*Married  Widowed  Divorced

Social Security # \_\_\_\_\_

Drivers License # \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Employer Phone ( ) \_\_\_\_\_

(Please check in the box next to the best way(s) to reach you)

Home Phone( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

Text to cell is ok

## \*INFORMATION ABOUT YOUR SPOUSE

Name \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Employer Phone ( ) \_\_\_\_\_

**As a courtesy service to our patients,** we will bill your insurance company, as long as you have provided all necessary information. Your insurance policy is a contract between you, your employer and the insurance company. Insurance policies vary and services provided may not be covered. We cannot guarantee insurance payment, as the insurance carrier will not guarantee payment before a claim is received. Please contact your employer or insurance carrier if you have questions about your policy coverage.

### PRIMARY CARRIER

(Self, unless you do not have your own coverage)

Name of Insured \_\_\_\_\_

Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID/Social Security # \_\_\_\_\_

### SECONDARY CARRIER

(Spouse, if you have your own coverage)

Name of Insured \_\_\_\_\_

Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID/Social Security# \_\_\_\_\_

I, the undersigned certify that I(or my dependant) have insurance coverage with \_\_\_\_\_ and assign directly to **Dr. Capinpin** 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 Dr. Capinpin to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions.

Signature

Date

Relationship (to subscriber)

## GENERAL INFORMATION

Whom may we thank for referring you? \_\_\_\_\_

Are you available for appointment on short notice? \_\_\_\_\_

Contact \_\_\_\_\_ in case of an emergency. Phone( ) \_\_\_\_\_

### CONSENT FOR DENTAL TREATMENT

I hereby give consent to any advisable and necessary dental procedures, medications, anesthetics or necessary radiographs (x-rays), to be administered by Dr. Allan Capinpin or the supervised licensed staff for diagnosis and treatment of my dental condition.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**Patients Name:** \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Kaiser ID# \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Have you been under the care of a medical doctor during the past two years? ..... Yes No  
If yes, for what \_\_\_\_\_  
Have you been a patient in the hospital during the past five years? ..... Yes No  
If yes, for what \_\_\_\_\_

*Due to constant changes in the medical and dental health fields it is very important of Dr. Capinpin to know about your over all health. Please circle "yes" or "no" if you have or have had any of the following:*

- |                                      |                                   |                               |
|--------------------------------------|-----------------------------------|-------------------------------|
| yes no Anemia                        | yes no Diet (special, restricted) | yes no Liver Disease          |
| yes no Angina Pectoris               | yes no Diabetes                   | yes no Nervous/Anxious        |
| yes no Arthritis/Rheumatism          | yes no Eating Disorders           | yes no Neurological Disorders |
| yes no Artificial Heart Valve        | yes no Emphysema                  | yes no Psychiatric Care       |
| yes no Artificial Joints (hip, knee) | yes no Epilepsy/Seizures          | yes no Psychological Care     |
| yes no Asthma                        | yes no Fainting/Dizzy Spells      | yes no Radiation Therapy      |
| yes no Back Problems                 | yes no Glaucoma                   | yes no Swollen Ankles         |
| yes no Blood Transfusion             | yes no Headaches                  | yes no S.T.D.                 |
| yes no BRONJ                         | yes no Heart Disorder             | yes no Stroke                 |
| yes no Bruise Easily                 | yes no Heart Infection            | yes no Sinus Trouble          |
| yes no Cancer                        | yes no Heart Valve Replacement    | yes no Sickle Cell Disease    |
| yes no Chemotherapy                  | yes no High Blood Pressure        | yes no Thyroid (high, low)    |
| yes no Chest Pain                    | yes no Heart Pacemaker            | yes no Tuberculosis           |
| yes no Chronic Cough                 | yes no Hay Fever                  | yes no Tumors                 |
| yes no Cold Sores/Fever Blisters     | yes no Hepatitis (a, b, c)        | yes no Ulcers                 |
| yes no Congenital Heart Disease      | yes no Hemophilia                 | yes no Yellow Jaundice        |
| yes no Contact Lens                  | yes no H.I.V/A.I.D.S              |                               |
| yes no Cortisone Treatments          | yes no Kidney Trouble             |                               |

Any other conditions not listed? \_\_\_\_\_

**MEDICATIONS**

List medications you are currently taking \_\_\_\_\_

List herbal remedies or vitamins you take \_\_\_\_\_

**ALLERGIES**

Are you aware of having an allergic (or adverse reaction) to any medications or substance? \_\_\_\_\_

If yes, please list \_\_\_\_\_

- Have you ever had IV Bisphosphonate Therapy? ..... Yes No
- Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin/Adipex/ Fastin (brand name for phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine)..... Yes No
- Have you lost or gained more than 10 pounds in the past year? ..... Yes No
- Do you use more than two pillows to sleep?..... Yes No
- Do you smoke or use other tobacco products..... Yes No

**WOMEN**

Are you: Pregnant? .....Yes (months \_\_\_\_\_) Nursing? ..... Yes No

Taking Birth control Pills? ..... Yes No

Using oral Bisphosphonate for Hormone Replacement Therapy (Fosamax, Actonel, Boniva)?... Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and I understand that it is my responsibility to inform the doctor if I ever have a change in health or medication.*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date