Today's Date: ____________________

Barbara Galera DDS, INC.
512 Westline Drive, Suite 302
Alameda, CA 94501
(510) 522-7520

Patient Information

Patient Name: ______________________________ ❑ Male ❑ Female
Last First MI

What you prefer to be called: ____________ Birth Date: ___/___/___ Age: ______ SS#: ____________

Home Address: ______________________________ Home Ph: ____________
Street City State Zip

Employer: ______________ Occupation: ______________ Cell Ph: ____________

Work Address: ______________________________ Work Ph: ____________
Street City State Zip

Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed E-Mail: ____________

Spouse's Name: ______________ Do you have any Children? ❑ No ❑ Yes How many? ______

Whom may we thank for referring you? ____________________

Primary Dental Insurance

Company Name: ______________________________ Phone: ( ) ____________

Address: ______________________________
Street City State Zip

Insured's Name: ______________ Insured's SS#: ______________ Group #: ____________

Insured's Employer: ______________ Insured's Relation: ______________ Date of Birth: ___/___/___

Secondary Dental Insurance

Company Name: ______________________________ Phone: ( ) ____________

Address: ______________________________
Street City State Zip

Insured's Name: ______________ Insured's SS#: ______________ Group #: ____________

Insured's Employer: ______________ Insured's Relation: ______________ Date of Birth: ___/___/___

Financial Information – Person Ultimately Responsible for Account

Name: ______________________________ ❑ Male ❑ Female
Last First MI

Billing Address: ______________________________ Work Ph: ____________
Street City State Zip

SS #: ______________ Driver's License #: ______________ Relationship to Patient: ____________

Payment Method: ❑ Cash ❑ Check ❑ Credit Card Card No. ______________ Exp. ___/___

Initials: ______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

In Event of Emergency

Whom should we contact? ______________________ Relation: ____________

Home Ph: ______________ Work Ph: ______________ Cell Phone: ____________

Who is your Medical Doctor? ______________________ Medical Doctor's Ph: ____________

Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How long? __________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping jaw ❑ Lost/Broken filling (s) ❑ Stained teeth ❑ Locking jaw
❑ Sensitive tooth, teeth or gums ❑ Teeth grinding ❑ Bad breath ❑ Ringing in ears
❑ Blisters/Sores in or around the mouth ❑ Broken / Chipped tooth ❑ Red, swollen or bleeding gums
❑ Other ______________________________

Do you require medication prior to treatment? ❑ Yes ❑ No ❑ Don't Know If yes, please specify: __________

Previous Dentist? ______________________ Previous Dentist Ph: __________

Last Dental Exam: ___/___/___ Last Dental X-Rays: ___/___/___ Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

What would you like to change about your smile? ______________________

Medical History

Date of Last Physician's Exam: ___/___/___ Reason for Visit: ______________________

Have you or are you taking any of the following medications? ❑ Zometa ❑ Aredia ❑ Fosamax ❑ Boniva ❑ Actonel
❑ Insulin ❑ Muscle relaxers ❑ Stimulants ❑ Tranquilizers ❑ Pain killers (including aspirin) ❑ Blood Thinners
❑ Anti-Depressants ❑ Biphosphonates ❑ Other(s), please list: ______________________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Office Use Only: BP: ______________ Pulse: __________

	Yes	No		Yes	No		Yes	No
Heart Attack / Stroke	❑	❑	Stomach Problems / Ulcers	❑	❑	Frequent Neck Pain	❑	❑
Heart Surgery / Pacemaker	❑	❑	Psychiatric Problems	❑	❑	Back Problems	❑	❑
Heart Murmur	❑	❑	Venereal Disease	❑	❑	Cosmetic Procedures	❑	❑
Rheumatic Fever	❑	❑	Alcohol/Drug Abuse	❑	❑	X-Ray or Cobalt Treatment	❑	❑
Mitral Valve Prolapse	❑	❑	Tuberculosis (TB)	❑	❑	Chemotherapy	❑	❑
Artificial Valves	❑	❑	Jaw Problems TMJ/TMD	❑	❑	Asthma	❑	❑
Heart Disease	❑	❑	Cancer/Tumors	❑	❑	Difficulty Breathing	❑	❑
Congenital Heart Defect	❑	❑	Shingles	❑	❑	Diabetes / Hypoglycemia	❑	❑
Chest Pains	❑	❑	Hepatitis	❑	❑	Leukemia	❑	❑
Scarlet Fever	❑	❑	HIV+/AIDS/ARC	❑	❑	Anemia	❑	❑
Thyroid Problems	❑	❑	Arthritis/Rheumatism	❑	❑	High / Low Blood Pressure	❑	❑
Kidney Problems	❑	❑	Artificial Bones/Joints	❑	❑	Bleeding Problems	❑	❑
Liver Problems	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Respiratory Problems	❑	❑	Fainting/Seizures/Epilepsy	❑	❑			
Sinus Problems	❑	❑	Severe / Frequent Headaches	❑	❑			

Please list any other surgeries or medical conditions you have or ever had: ______________________

Are you allergic to any of the following: ❑ Latex ❑ Penicilin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics
❑ Other(s), please list: ______________________

Do you use tobacco? ❑ No ❑ Yes / How Used? __________ How much? __________ How long? __________

Have you ever taken Phen-fen and or Redux? ❑ Yes ❑ No Do you wear contact lenses? ❑ Yes ❑ No

For Women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? __________

Are you pregnant? ❑ No ❑ Yes/How long? Are you nursing? ❑ Yes ❑ No

Is snoring a problem in your household? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ______________________ Date: __________ Reviewed By: __________

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse Date: __________

Acknowledgement of Receipt of HIPPA ______ (Initial) Acknowledgement of Receipt of DMFS ______ (Initial)

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