Dr. Joanna El-Maasri Reppas
Dr. Constantine N. Reppas

SAN MARCOS
FAMILY DENTAL

1 Civic Center Drive
Suite 230
San Marcos, CA 92069
(760) 798-4178

Patient Information

We are delighted that you have chosen our office to provide your personalized dental care. We look forward to getting to know you, not only as a patient but also as our friend! Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: First _____ MI____ Last_____ Preferred:_____

Birth Date: _____ **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Email Address: _____ **Best time to call:** _____

Phone: Home_____ Work_____ Mobile_____

Address: _____

City: _____ State: _____ Zip Code: _____

Whom may we thank for referring you to our practice or How did you hear about us?

_____ _____

Emergency Contact:

Name: _____ Relationship:_____

Phone number: _____

Responsible Party:

(If different from patient)

Patient Name: _____

Phone Number: _____ **E-mail Address:** _____

Address: _____

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Medical Health History

Patient Name: _____**Date of Birth:**_____

I. Please Circle Yes or No and Explain as needed:

1. Yes / No Is your general health good? If No explain: _____

2. Yes / No Has there been a change in your health within the last year? If YES, explain:
_____

3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain: _____

4. Yes / No Are you being treated by a physician now? If YES, explain:
Date of last medical exam & Reason:_____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	**Yes / No**	Headaches	**Yes / No**	Joint pain or stiffness
Yes / No	Shortness of Breath	**Yes / No**	Difficulty swallowing	**Yes / No**	Recent significant weight loss
Yes / No	Fainting spells	**Yes / No**	Dry mouth	**Yes / No**	Frequent vomiting
Yes / No	Dizziness	**Yes / No**	Excessive thirst	**Yes / No**	Bleeding problems
Yes / No	Persistent cough	**Yes / No**	Sinus problems	**Yes / No**	Bruise easily
Yes / No	Fever	**Yes / No**	Ringing in ears		

If **YES** to any of the above, please briefly explain:

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	**Yes / No**	Asthma	**Yes / No**	Eye disease
Yes / No	High blood pressure	**Yes / No**	Emphysema or other lung disease	**Yes / No**	Skin disease
Yes / No	Hardening of arteries	**Yes / No**	Tuberculosis	**Yes / No**	Herpes
Yes / No	Stroke	**Yes / No**	Thyroid disease	**Yes / No**	Canker or cold sores
Yes / No	Heart murmurs	**Yes / No**	Liver disease	**Yes / No**	Arthritis, rheumatism
Yes / No	Heart attack	**Yes / No**	Kidney or bladder disease	**Yes / No**	Osteoporosis
Yes / No	Heart defects	**Yes / No**	Stomach problems or ulcers	**Yes / No**	Artificial joint
Yes / No	Rheumatic fever	**Yes / No**	Hepatitis	**Yes / No**	Hospitalization
Yes / No	Anemia	**Yes / No**	AIDS/HIV	**Yes / No**	Surgeries
Yes / No	Diabetes	**Yes / No**	Tumors or cancer	**Yes / No**	Transplants
Yes / No	Family history of diabetes	**Yes / No**	Chemotherapy	**Yes / No**	Psychiatric care
Yes / No	Seizures	**Yes / No**	Radiation	**Yes / No**	Eating disorders

If **YES** to any of the above, please briefly explain:

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IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Latex	**Yes / No**	Sulfa Drugs	**Yes / No**	Nitrous oxide
Yes / No	Penicillin/Amoxicillin	**Yes / No**	Codeine	**Yes / No**	Metal
Yes / No	Erythromycin	**Yes / No**	Vicodin/ Norco	**Yes / No**	Ibuprofen
Yes / No	Tetracycline	**Yes / No**	Percocet	**Yes / No**	Aspirin
Yes / No	Local anesthetic	**Yes / No**	Valium	**Yes / No**	Food

List any **other** allergies not covered above:

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No	Antibiotics	**Yes / No**	Recreational drugs	**Yes / No**	Supplements
Yes / No	Over-the-counter medicines	**Yes / No**	Tobacco in any form	**Yes / No**	Weight loss medications
Yes / No	Aspirin	**Yes / No**	Alcohol	**Yes / No**	Bisphosphonate (Fosamax)

VI. IF APPLICABLE (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Please list **all prescription medications** and reasons for taking them:

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.
I authorize the dentist to contact my physician.

Physician's Name: _____ Phone Number:_____

Patient's Signature: _____ Date: _____

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Dental Health History

Patient Name: _____**Date of Birth:**_____

What are your goals in coming to our practice today?_____
What is important to you in a dentist or dental practice?_____
What has been your experience with the dentist in the past?_____
Date of last Radiographs (x-rays) & exam _____
Date of last hygiene appointment *(cleaning or periodontal maintenance)*_____
Former Dentist: _____Phone:_____
If you left your previous dentist, what are the reasons? _____
Have you had problems with prior dental treatment?_____
Are you experiencing any pain now? Yes/No Describe: _____
Have you ever been pre-medicated for dental treatment? Yes/No Why?_____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

- Jaw Joint Pain
- Clenching or grinding of teeth
- Uncomfortable bite
- Loose tooth/ teeth
- Missing teeth
- Difficulty chewing
- Food gets caught between teeth
- Where_____
- Tooth Sensitivity to hot/cold or anything else
- Old fillings (gold or silver)
- Old crowns
- Bad Breath
- Unhappy with appearance of teeth
- Discolored teeth
- Crowded/ Crooked teeth
- Spaces between teeth
- Tooth shape/ size
- Overbite
- Under-bite
- Speech problems
- Too much gum tissue when I smile
- Other

Have you ever had Orthodontic treatment? Yes/No When?_____
Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or Surgery? Yes/No What/ When?_____
Have you Whitened your teeth in the past? Yes/ No Method: _____

Are you interested in learning more about the following? *(check all that apply)*

- Teeth Whitening
- Orthodontic Treatment
- Veneers
- Tooth-colored fillings
- Dental implants
- How to prevent periodontal disease
- At-Home oral hygiene care
- Periodontal treatment during pregnancy
- Oral hygiene care for infants and toddlers

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian):_____ Date:_____

Signature of Dentist: _____Date:_____