Aliso Viejo Office
DonchevaDDS.Inc@gmail.com

Tsvetanka Doncheva DDS
PATIENT REGISTRATION

Placentia Office
YoLindaFamilyDentistry@gmail.com

Patient Information

First Name: ________________ Last Name: ________________ Middle Initial: ________

Preferred Name: ________________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date: ________________ SS#: ________________ Drivers Lic: ________________

Address: ________________ Apt/Unit # :________________

City, State, Zip: ________________ E-mail: ________________

Home Phone: ________________ Cell Phone: ________________ Work phone: ________________

Guardian or Responsible Party (If patient is under 18 years of age)

First Name: ________________ Last Name: ________________ Middle Initial: ________

Preferred Name: ________________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Birth Date: ________________ SS#: ________________ Drivers Lic: ________________

Address: ________________ Apt/Unit # :________________

City, State, Zip: ________________ E-mail: ________________

Home Phone: ________________ Cell Phone: ________________ Work phone: ________________

Primary Insurance Information

Policy Holder: ________________ Relationship to Patient: O Self O Spouse O Child O other

Policy Holder's Soc Sec/ID#: ________________ Policy Holder's Birth Date: ________________

Employer:________________

Insurance Company: ________________ Insurance Phone: ________________

Secondary Insurance Information

Policy Holder: ________________ Relationship to Patient: O Self O Spouse O Child O other

Policy Holder's Soc Sec/ID#: ________________ Policy Holder's Birth Date: ________________

Employer:________________

Insurance Company: ________________ Insurance Phone: ________________

Others

Referred by: ________________

Previous Dentist Name: ________________ Previous Dentist Phone #:________________

Primary Care Doctor: ________________ Primary Care Doctor Phone #: ________________

Emergency Contact Name: ________________ Emergency Contact Phone #:________________

Notes

____

____

X________________
Signature of Patient, Parent or Guardian

X________________
Date

Tsvetanka Doncheva DDS

MEDICAL HISTORY FORM

Name: ____ Date of Birth: ______________________

Are you under a physician's care now?	O Yes	O No	If yes ____________________
Have you ever been Hospitalized or had a major Operation?	O Yes	O No	If yes ____________________
Have you ever had a serious head or neck injury?	O Yes	O No	If yes ____________________
Are you on a special diet?	O Yes	O No	If yes ____________________
Do you use tobacco?	O Yes	O No	If yes ____________________
Do you use any controlled substances?	O Yes	O No	If yes ____________________
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If yes ____________________
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing **bisphosphonates?**	O Yes	O No	If yes ____________________
Are you taking any medications, pills, vitamins, or Drugs?	O Yes	O No	If yes ____________________

____

Women: Are You… O Pregnant/Trying to get pregnant O Nursing O Taking Oral contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drugs

O Local Anesthetics O Others?____

Do you have, or have you had, any of the following?

- AIDS/HIV Positive…………..O Yes O No
- Alzheimer's Disease…………O Yes O No
- Anaphylaxis……………………O Yes O No
- Anemia………………………….O Yes O No
- Angina…………………………..O Yes O No
- Arthritis/Gout…………………O Yes O No
- Artificial Heart Valve…………O Yes O No
- Artificial Join…………………..O Yes O No
- Asthma………………………….O Yes O No
- Blood Disease…………………O Yes O No
- Blood Transfusion……………O Yes O No
- Breathing Problems…………O Yes O No
- Bruise Easily…………………..O Yes O No
- Cancer…………………………..O Yes O No
- Chemotherapy………………..O Yes O No
- Chest Pains……………………O Yes O No
- Cold Sores/Fever Blisters…..O Yes O No
- Congenital Heart Disorder…..O Yes O No
- Convulsions……………………O Yes O No

- Cortisone Medicine …..O Yes O No
- Diabetes………………..O Yes O No
- Drug Addiction…………O Yes O No
- Easily Winded…………..O Yes O No
- Emphysema…………….O Yes O No
- Epilepsy or Seizures…..O Yes O No
- Excessive Bleeding……O Yes O No
- Excessive Thirst……….O Yes O No
- Fainting Spells/Dizziness.O Yes O No
- Frequent Cough……….O Yes O No
- Frequent Diarrhea……..O Yes O No
- Frequent Headaches …O Yes O No
- Genital Herpes ………..O Yes O No
- Glaucoma………………O Yes O No
- Hay Fever………………O Yes O No
- Heart Attack/Failure…..O Yes O No
- Heart Murmur………….O Yes O No
- Heart Pacemaker………O Yes O No
- Heart Trouble/Disease…O Yes O No

- Hemophilia…………O Yes O No
- Hepatitis A…………O Yes O No
- Hepatitis B or C……O Yes O No
- Herpes………………O Yes O No
- High Blood Pressure…O Yes O No
- High Cholesterol…..O Yes O No
- Hives or Rash………O Yes O No
- Hypoglycemia………O Yes O No
- Irregular Heartbeat…O Yes O No
- Kidney Problems……O Yes O No
- Leukemia……………O Yes O No
- Liver Disease……….O Yes O No
- Low Blood Pressure….O Yes O No
- Lung Disease……….O Yes O No
- Mitral Valve Prolapse…O Yes O No
- Osteoporosis……….O Yes O No
- Pain in Jaw joints….O Yes O No
- Parathyroid Disease…O Yes O No
- Psychiatric Care……O Yes O No

- Radiation Treatments……..O Yes O No
- Recent Weight Loss………O Yes O No
- Renal Dialysis……………..O Yes O No
- Rheumatic Fever…………O Yes O No
- Rheumatism………………O Yes O No
- Scarlet Fever………………O Yes O No
- Shingles……………………O Yes O No
- Sickle cell Disease………..O Yes O No
- Sinus Trouble ……………..O Yes O No
- Spina Bifida………………O Yes O No
- Stomach/Intestinal Disease..O Yes O No
- Stroke………………………O Yes O No
- Swelling of Limbs…………O Yes O No
- Thyroid Disease……………O Yes O No
- Tonsilitis……………………O Yes O No
- Tuberculosis………………..O Yes O No
- Tumors or Growths……….O Yes O No
- Ulcers……………………….O Yes O No
- Venereal Disease…………..O Yes O No
- Yellow Jaundice……………O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If yes, ______________________

Has a physician or dentist recommended that you take antibiotics prior to your dental appointment? O Yes O No

If yes, what do you normally take?____

What is the reason for your visit today?______________________________________

____

X______________________________________ **X**______________________

Signature of Patient, Parent or Guardian Date