Dr. Bruce Goldman and Dr. Vi Lau
265 E Street, Suite E
Chula Vista, CA 91910
619-427-9440

Welcome

Who may we thank for referring you to our office? ____

Personal Information

Name: ____
I like to be called ____
Address: __________________________________ City ___________ Zip _____________________
Employer ____
Name of Spouse (If child, name of parents) ____
Patient's Age _____ Date of Birth ______________ Social Security Number ___________________
Contact Information: Home phone: ____________________ Work phone: _____________________
Cell phone: ________________________ Email Address: ________________________________
In case of emergency, who can we contact? ____
Relationship ____________________________________ Phone: ____________________________

Medical History

Are you in good health? ☐Yes ☐No Name of Physician: ____________________________________
Date of last physical? ____________________________ Their phone number ____________________
Are you currently being treated by your physician? ☐Yes ☐No
Have you ever had a serious illness or operation? ☐Yes ☐No
Are you taking any medicine? (Including aspirin) ☐Yes ☐No
If so, what? ____
Do you require antibiotics prior to dental treatment? ☐Yes ☐No
Are you sensitive or allergic to any drug, metal, or latex? ______________________________
Are there any other medical concerns we need to know about? ______________________________
____

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

Yes/No	**Yes/No**	**Yes/No**	**Yes/No**
( ) ( ) Alcoholism	( ) ( ) Cortisone Meds.	( ) ( ) High Blood Pressure	( ) ( )Rheumatic Fever
( ) ( ) Anemia	( ) ( ) Diabetes	( ) ( ) HIV/AIDS	( ) ( ) Rheumatism
( ) ( ) Arthritis	( ) ( ) Drug Addiction	( ) ( ) Joint Replacement	( ) ( ) Sickle Cell disease
( ) ( ) Artificial Heart Valve	( ) ( ) Emphysema	( ) ( ) Kidney problems	( ) ( ) Sinus problems
( ) ( ) Asthma	( ) ( ) Epilepsy/Seizure	( ) ( ) Latex Sensitivity	( ) ( ) Steroid medication
( ) ( ) Bleed Easily	( ) ( ) Fainting	( ) ( ) Liver Disease	( ) ( ) Stroke
( ) ( ) Blood Transfusion	( ) ( ) Glaucoma	( ) ( ) Menopause	( ) ( ) Thyroid
( ) ( ) Cancer	( ) ( ) Heart Attack	( ) ( ) Mitral Valve Prolapse	( ) ( ) Tuberculosis
( ) ( ) Chemotherapy	( ) ( ) Heart Murmur	( ) ( ) Pacemaker	( ) ( ) Tumors
( ) ( ) Chest Pain/Angina	( ) ( ) Heart Surgery	( ) ( ) Persistent Cough	( ) ( ) Ulcers
( ) ( ) Cold Sores	( ) ( ) Hemophilia	( ) ( ) Psychiatric problems	( ) ( ) Venereal Disease
( ) ( ) Congenital Heart	( ) ( ) Hepatitis Type:	( ) ( ) Radiation Therapy	

Do you smoke? □Yes □No   Do you drink alcoholic beverages? □Yes □No
How much? ____
Female: Are you taking birth control pills? □Yes □No   Are you pregnant? □Yes □No

Dental History

How long since your last dental visit? ____________   Were x-rays taken? □Yes □No
Are you currently in pain? □Yes □No
Have you ever had an unfavorable experience in a dental office? □Yes □No
Please explain: ____
Have you ever had any of your teeth removed? □Yes □No
Have you ever had abnormal bleeding after a cut or extraction? □Yes □No
Have you ever been treated for gum disease? □Yes □No
Do your gums bleed when brushing or flossing? □Yes □No
Are any of your teeth sensitive to hot, cold, sweets or pressure? □Yes □No
Do you clench or grind your teeth? □Yes □No
Have you ever had orthodontic treatment? □Yes □No
Have you had any serious trouble associated with previous dental treatment? □Yes □No
Please explain: ____
Does dental treatment make you nervous? □Yes □No
Have you ever experienced TMJ (Jaw joint) problems? □Yes □No

About your smile:

Are you delighted with your smile? □Yes □No
Please rate your smile from 1 to 10 (1 = truly dislike, 10 = love it) ____________________________
If you could do anything to change your smile, what would it be? ______________________________
____
If there were a simple way to straighten teeth without braces, would you be interested? □Yes □No
Are you happy with the color of your teeth? □Yes □No
Would you like to have your Metal/Mercury fillings removed? □Yes □No
Do you have any special occasions coming up? □Yes □No

Insurance Information

Primary Carrier	Secondary Carrier
Name of Employee _________________________	Name of Employee _________________________
ID Number ________________________________	ID Number ________________________________
Birthday _________________________________	Birthday _________________________________
Insurance Company _________________________	Insurance Company _________________________
Address __________________________________	Address __________________________________

I understand that the above information is correct to the best of my knowledge, and that it will be held in the strictest confidence and only used to improve communication between Dr. Goldman, his associates and myself. I also give permission to Dr. Goldman and his associates, to use any photos they may take for lecturing or education purposes.

I authorize the release of information to my insurance carrier and also authorize payment to be made directly to Dr. Goldman. As a courtesy to you, we will submit claims for payments to your insurance company. Payment for treatment is due at the time of service. If collection services are required, I authorize personal and clinical information release to agency for that purpose.

Signature ________________________________ Date __________________________________