Robert A. Turner, DDS, Inc.
General & Cosmetic Dentistry
2288 North State College Blvd.
Fullerton, CA 92831
(714) 990-2057 Office
(714) 990-2079 Fax

We are delighted to welcome you to our practice and pleased that you chose us to serve your dental needs. We are committed to providing excellent dental care at reasonable fees and we are dedicated to serving our patients. Our goal is to help you feel and look your best through excellent dental care. We look forward to seeing you on a regular basis.

If you are ever unable to make an appointment you have scheduled with us, please notify us at least 72 hours in advance so that we may offer the time to other patients for care. We would be glad to reschedule the appointment at a more convenient time if necessary. In the meantime, we look forward to seeing you and serving your needs. Please bring the completed health history form and dental/medical insurance cards along to your appointment.

Sincerely,

Robert A. Turner, D.D.S.

Dr Robert A. Turner, DDS, Inc.
2288 N. State College Blvd..
Fullerton, CA 92831
(714) 990-2057

Dental Health History

Date: ________________

Name: ______________________________ Date of Birth: _________ Age: ________

SS#: _______________________________ DL#: ____________________________

Home Phone #:______________________ Cell Phone #:________________________

Work Phone #:______________________ E-Mail Address______________________

Home Address: ____

___Married ____Divorced ___Separated ____Widowed ___Single

Patient Employer/School_______________________ Occupation: _________________________

Address: ____

Spouse name: ________________________ Date of Birth: ___________ Age:_______

Employer: ___________________________ Work #: _______________

Whom may we thank for referring you? ____

IN CASE OF EMERGENCY, CONTACT (someone who does not live in your household)

Name: _____________________________ Relationship: ____________________

Home Phone #: ______________________ Work Phone #: ___________________

Physicians Name: ____________________________ Phone #: ________________________

Address: ____________________________________ Date of last visit: _________________

Primary Dental Information

Subscribers Name: ___________________________ Date of Birth: ________________________

Insurance Co. Name: __________________________ Address: ____________________________

Subscribers ID #: ____________________________ Group #: ____________________________

Relationship to Insured: _______________________

Secondary Dental Information

Subscribers Name: ___________________________ Date of Birth: _______________________

Insurance Co. Name: __________________________ Address: ____________________________

Subscribers ID #: ____________________________ Group #: ____________________________

Relationship to Insured: _______________________

I certify that I and/or my dependents have coverage with the listed insurance co. above and assign directly to Dr. Robert A. Turner, DDS, Inc. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submission. Dr Robert A. Turner, DDS, Inc. may use my dental card information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits to the benefits payable for related services.

Signature: ____ Date: ________________________

Print Name: ____

Medical History

Do you smoke or use tobacco in any other form? Y N

Have you had metal rods, pins or implants? Y N
Have you ever taken Phen-Fen? Y N
Do you require antibiotics before dental treatment? Y N
Are you currently in pain? Y N
Have you ever had gum treatment? Y N
Have you had joint replacements? Y N

Women Only:
Are you pregnant? Y N
Are you nursing? Y N
Are you using prescribed method of birth control? Y N

Please list all medications, prescription/ over the counter herbal supplements.

____
____
____

Have you ever had any of the following diseases or medical problems:

Y N	Abnormal Bleeding		Y N	Alcohol/drug abuse		Y N	Anemia
Y N	Arthritis		Y N	Artificial Bones/Joints		Y N	Asthma
Y N	Blood Transfusion		Y N	Cancer/Chemo		Y N	Colitis
Y N	Congenital Heart Defect		Y N	Diabetes		Y N	Emphysema
Y N	Difficulty Breathing		Y N	Epilepsy		Y N	Fainting Spells
Y N	Frequent Headaches		Y N	Glaucoma		Y N	Hay Fever
Y N	Heart Attack		Y N	Heart Murmur		Y N	Heart Surgery
Y N	Hemophilia		Y N	Ulcers		Y N	HIV/AIDS
Y N	Herpes/Fever blisters		Y N	High Blood pressure		Y N	Hepatitis
Y N	Hospitalized for any reason		Y N	Kidney Problems		Y N	Liver Disease
Y N	Low Blood Pressure		Y N	Mitral Valve Prolapse		Y N	Lupus
Y N	Pacemaker		Y N	Psychiatric Care		Y N	Seizures/epilepsy
Y N	Radiation Treatment		Y N	Scarlet/Rheumatic fever		Y N	Shingles
Y N	Sickle Cell Disease		Y N	Sinus Problems		Y N	Stroke
Y N	Thyroid Problems		Y N	Tuberculosis (TB)			
Y N	Back Problems		Y N	Venereal Disease			

Are you allergic to any of the following:

Y N	Aspirin		Y N	Erythromycin		Y N	Codeine
Y N	Tetracycline		Y N	Penicillin		Y N	Latex
Y N	Dental Anesthetics		Y N	Sulfa Drugs			
	Other: ______________________________						

Our office is HIPPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. I understand that the information that I have given today is correct to the best of my knowledge. I understand that regardless of the insurance coverage that I have, I am responsible for paying all charges.

Signature:____ Date: ______________

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY
I verbally reviewed the medial/dental information above with the patient named herein. Initials: _________ Date: ___________

I have read my medical health history dated _______and confirmed that it states past and present medical conditions.
Signature______________________________________ Date:

REQUEST FOR DENTAL CLEARANCE

Patient:

Date of Birth:

The above patient has indicated that he/she is under your care for an ongoing medical condition. So that we can safely proceed with our patient's dental care, please complete this form and return it to our office via fax at your earliest opportunity.
Thank you!

1) Is pre-medication required prior to dental treatment? If so, please indicate the medication, strength and dosage.

2) Are there any contraindications to epinephrine?

3) Are there any other restrictions that we should be aware of before beginning dental treatment or dental cleanings?

______________________________________ ____________
Physician's Signature Date

____
Please Print Name

____
Physician's Name and Address

____
Area Code and Phone Number

____

____

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