



## Welcome to Valley View Dental

The dental office of John T. Bianchin, D.D.S.

“My commitment is providing patients with brilliant smiles. Quality time...quality care...one guest at a time!”

### Patient Information

Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_ SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street

City State Zip Code

### Contact Information

Home Phone: \_\_\_\_\_ WorkPhone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Our office is now able to send you appointment reminders and dental care information to your cell phone, email and/or pda. Smile Reminder is free of charge.

### Who may we thank for referring you to our practice?

- Another Patient/Friend: \_\_\_\_\_
- Dr. \_\_\_\_\_
- Phone Book
- Rancho Mirage Chamber Of Commerce
- Healthy Living (Eisenhower Medical Magazine)
- KMIR 6 Television Commercial
- Desert Magazine
- Web Site
- Your Health Magazine
- Other: \_\_\_\_\_

### Authorization and Release

At Valley View Dental, we are very proud of the work we have done and only use our own patients in our marketing.

I \_\_\_\_\_ authorize Dr. John Bianchin to take photographs of my face, jaws and teeth. I understand that the photographs will be used as a record of my care, and may be used for educational purposes, advertising (including website publication, newspapers, magazines, phone books), and professional publications. I further understand that if the photographs are used in any publication or demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: \_\_\_\_\_

## Medical Information

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems.

Date of Last Medical Exam \_\_\_\_\_

Physician: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

\_\_\_\_\_

List any medications you are currently taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently under medical treatment? \_\_\_\_ Yes No \_\_\_\_

Explain: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

### Have you had any of the following?

Heart Surgery, disease, attack \_\_\_\_\_ Yes No \_\_\_\_

Heart Murmur \_\_\_\_\_ Yes No \_\_\_\_

High Blood Pressure \_\_\_\_\_ Yes No \_\_\_\_ How is it controlled? \_\_\_\_\_

Pain in your chest or shortness in breath \_\_\_\_\_ Yes No \_\_\_\_

Mitral Valve prolapse (dysfunction) \_\_\_\_\_ Yes No \_\_\_\_

Artificial Heart Valve \_\_\_\_\_ Yes No \_\_\_\_

Pacemaker \_\_\_\_\_ Yes No \_\_\_\_

Rheumatic Fever \_\_\_\_\_ Yes No \_\_\_\_ When? \_\_\_\_\_

Arthritis/Rheumatism \_\_\_\_\_ Yes No \_\_\_\_

Cortisone Medicine \_\_\_\_\_ Yes No \_\_\_\_

Ankles ever swell \_\_\_\_\_ Yes No \_\_\_\_

Anemic \_\_\_\_\_ Yes No \_\_\_\_

Are you subject to fainting or dizziness \_\_\_\_\_ Yes No \_\_\_\_

Stroke \_\_\_\_\_ Yes No \_\_\_\_ When? \_\_\_\_\_

Ulcers \_\_\_\_\_ Yes No \_\_\_\_

Diabetes \_\_\_\_\_ Yes No \_\_\_\_ How is it controlled? \_\_\_\_\_

Thyroid Problems \_\_\_\_\_ Yes No \_\_\_\_

Kidney Trouble \_\_\_\_\_ Yes No \_\_\_\_

Hepatitis \_\_\_\_\_ Yes No \_\_\_\_ When? \_\_\_\_\_

Liver Disease \_\_\_\_\_ Yes No \_\_\_\_

Yellow Jaundice \_\_\_\_\_ Yes No \_\_\_\_

Glaucoma \_\_\_\_\_ Yes No \_\_\_\_

Contact Lenses \_\_\_\_\_ Yes No \_\_\_\_

Artificial Joints or hip \_\_\_\_\_ Yes No \_\_\_\_

Emphysema \_\_\_\_\_ Yes No \_\_\_\_

Tuberculosis \_\_\_\_\_ Yes No \_\_\_\_

Allergic to any medications \_\_\_\_\_ Yes No \_\_\_\_ ( ) Penicillin ( ) Codeine ( ) Latex ( ) Other \_\_\_\_\_

Asthma, Hay Fever or Allergies \_\_\_\_\_ Yes No \_\_\_\_

Sinus Trouble \_\_\_\_\_ Yes No \_\_\_\_

Tonsil or Adenoid Problems \_\_\_\_\_ Yes No \_\_\_\_

Tonsil or Adenoid Surgery \_\_\_\_\_ Yes No \_\_\_\_

Tumor or Cancer \_\_\_\_\_ Yes No \_\_\_\_ How was it treated? \_\_\_\_\_

Major Operation \_\_\_\_\_ Yes No \_\_\_\_ What for? \_\_\_\_\_

Significant change in weight \_\_\_\_\_ Yes No \_\_\_\_ Loss \_\_\_\_\_ lbs Gain \_\_\_\_\_ lbs. When? \_\_\_\_\_

Diet medically supervised \_\_\_\_\_ Yes No \_\_\_\_ For what purpose? \_\_\_\_\_

Vitamin or mineral supplements \_\_\_\_\_ Yes No \_\_\_\_

## Medical Information Part II

Fatigue easily \_\_\_\_\_ Yes No \_\_\_\_\_  
Do you sleep well \_\_\_\_\_ Yes No \_\_\_\_\_ If no, what do you do? \_\_\_\_\_  
Snore \_\_\_\_\_ Yes No \_\_\_\_\_  
Sleep with bed elevated \_\_\_\_\_ Yes No \_\_\_\_\_  
Sleep with more than two pillows \_\_\_\_\_ Yes No \_\_\_\_\_  
Frequently not eat breakfast \_\_\_\_\_ Yes No \_\_\_\_\_  
More than one alcoholic drink per day \_\_\_\_\_ Yes No \_\_\_\_\_ How much a day? \_\_\_\_\_  
Smoke or use tobacco \_\_\_\_\_ Yes No \_\_\_\_\_ How much a day? \_\_\_\_\_  
Radiation Therapy \_\_\_\_\_ Yes No \_\_\_\_\_  
Chemotherapy \_\_\_\_\_ Yes No \_\_\_\_\_  
Tumors \_\_\_\_\_ Yes No \_\_\_\_\_  
Venereal Disease \_\_\_\_\_ Yes No \_\_\_\_\_  
A.I.D.S. \_\_\_\_\_ Yes No \_\_\_\_\_  
H.I.V. Positive \_\_\_\_\_ Yes No \_\_\_\_\_  
Blood transfusion \_\_\_\_\_ Yes No \_\_\_\_\_  
Hemophilia \_\_\_\_\_ Yes No \_\_\_\_\_  
Sickle Cell Disease \_\_\_\_\_ Yes No \_\_\_\_\_  
Bruise Easily \_\_\_\_\_ Yes No \_\_\_\_\_  
Nervous Disorders \_\_\_\_\_ Yes No \_\_\_\_\_  
Neurological Disorder \_\_\_\_\_ Yes No \_\_\_\_\_  
Epilepsy or Seizures \_\_\_\_\_ Yes No \_\_\_\_\_  
Fainting or Dizzy spells \_\_\_\_\_ Yes No \_\_\_\_\_  
Nervous/Anxious \_\_\_\_\_ Yes No \_\_\_\_\_  
Psychiatric/Psychological Care \_\_\_\_\_ Yes No \_\_\_\_\_

### For Women

Are you pregnant \_\_\_\_\_ Yes No \_\_\_\_\_ If yes, expected delivery date \_\_\_\_\_  
Are you taking birth control pills \_\_\_\_\_ Yes No \_\_\_\_\_  
(Antibiotics can interfere with birth control pills by causing them not to work)  
Ovulate regularly \_\_\_\_\_ Yes No \_\_\_\_\_  
Have you reached menopause \_\_\_\_\_ Yes No \_\_\_\_\_ Medications taken \_\_\_\_\_  
Have you had a hysterectomy \_\_\_\_\_ Yes No \_\_\_\_\_  
Have you been diagnosed having PMS \_\_\_\_\_ Yes No \_\_\_\_\_  
Do your nails break easily \_\_\_\_\_ Yes No \_\_\_\_\_  
Does cold weather bother you \_\_\_\_\_ Yes No \_\_\_\_\_

ANYTHING ELSE YOU FEEL WE NEED TO KNOW ABOUT THE SYSTEMS OF YOUR BODY \_\_\_\_\_ Yes No \_\_\_\_\_

### Authorization

I hereby authorize Dr. Bianchin and/or staff of Valley View Dental to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these medical and dental histories is correct to the best of my knowledge. I also authorize Dr. Bianchin and/or his staff to contact my healthcare giver concerning my treatment if necessary.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Today, we know deciphering your insurance benefits can be confusing. We are happy to help you with any insurance concern you may have. We do request payment at the time of service. We will gladly fill out the necessary paperwork for you to submit your claim. We feel, however, that your insurance should never dictate the quality or timing of your treatment. If you have extensive or long term dental care, our office offers financial assistance through Capital One's Healthcare Finance, an outside financing company with competitive interest rates as low as 1.9%.

## Dental History

Date of Last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

Dentist Name: \_\_\_\_\_

Address: \_\_\_\_\_

How often do you have a dental examination \_\_\_\_\_

Do you require medication prior to dental treatment? \_\_\_ Yes No \_\_\_ If yes \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss your teeth? \_\_\_\_\_

Do you use any other dental aids? \_\_\_ Yes No \_\_\_

Sonicare  Braun  Toothpick  Whitening  Other \_\_\_\_\_

Do you have active dental problems now? \_\_\_ Yes No \_\_\_

Gum Disease  Bleeding Gums  Decay  Broken teeth  Other \_\_\_\_\_

Do you have trouble with bad breath? \_\_\_ Yes No \_\_\_

Do you have any loose teeth? \_\_\_ Yes No \_\_\_ Where? \_\_\_\_\_

### Have you had or currently have any of the following?

Orthodontics treatment \_\_\_\_\_ Yes No \_\_\_\_\_

Oral surgery or teeth removed \_\_\_\_\_ Yes No \_\_\_\_\_

Periodontal treatment \_\_\_\_\_ Yes No \_\_\_\_\_

Endodontic treatment \_\_\_\_\_ Yes No \_\_\_\_\_

Teeth ground or the bite adjusted \_\_\_\_\_ Yes No \_\_\_\_\_

General anesthesia \_\_\_\_\_ Yes No \_\_\_\_\_

Broken jaw \_\_\_\_\_ Yes No \_\_\_\_\_

Missing back teeth with no replacement \_\_\_\_\_ Yes No \_\_\_\_\_

Denture or partial replacements \_\_\_\_\_ Yes No \_\_\_\_\_

Cortisone injected into joints \_\_\_\_\_ Yes No \_\_\_\_\_ When? \_\_\_\_\_ By whom? \_\_\_\_\_

Bite plate, splint, or mouth guard \_\_\_\_\_ Yes No \_\_\_\_\_ Cause? \_\_\_\_\_

Do you?

Clench or grind your teeth  Teeth hit in front first  Bite your cheek  Smoke a pipe  Bite your nails

Chew gum  Bite pencils  Tired jaws  Other \_\_\_\_\_

Are your teeth sensitive to:  Hot  Cold  Biting or chewing  Sweets

Do you have trouble with cold sores, blisters, or any other oral lesions? \_\_\_ Yes No \_\_\_

Have you ever had problems of prolonged bleeding either from a cut or dental procedure? \_\_\_ Yes No \_\_\_

Have you ever been involved in an accident or injury (sports injury, slips or falls etc.) \_\_\_ Yes No \_\_\_

When: \_\_\_\_\_

What happened: \_\_\_\_\_

Symptoms start after the accident? \_\_\_ Yes No \_\_\_

Explain: \_\_\_\_\_