Victoria V. Nisman, D.D.S. **Daniel C. Bacquet, D.M.D.**

17214 Saticoy Street Van Nuys, California 91406

Please Fill Out the Following Information for Our Records. All Information is Confidential.

1) Patient Information

Patient's Name_____ Date of Birth : _____ Age : _____ Gender: _____

Patient Prefers to be Called? Please circle : Mr. Mrs. Ms. Dr. Rev. by First Name by Nickname _____

Home Address : _____ City _____ Zip _____ Home Telephone : _____

Patient's Social Security # : _____ Marital Status : _____ Cell Telephone : _____

Patient's Employer Name : _____ Occupation : _____ How Long? _____

Work Address : _____ City _____ Zip _____ Work Telephone : _____

May We Contact You by ( ) Email and ( ) Text Messages? Email Address _____

Who Referred You to Our Office? Please circle : Family Friends Our Website Google Yelp Saw Sign/Office

Names of Family Members or Friends in our practice _____

Why are you seeing Dr. Bacquet today? Please circle : Checkup Examination Cleaning Toothache Sore Gums

or Other _____

2) Account Information

Responsible for Account (If not Patient) : _____ Relation to Patient _____

Billing Address : _____ City _____ Zip_____ Home Telephone : _____

Responsible's Social Security # : _____ Marital Status : _____ Cell Telephone : _____

Responsible's Employer Name : _____ Occupation : _____ How Long? _____

Work Address : _____ City _____ Zip _____ Work Telephone : _____

3) Dental Insurance	**Primary Insurance Information**	**Secondary Insurance Information**
Insured's Name :		
Relation to Patient :		
Insured's Birthday :		
Social Security # :		
Insured's Address :		
City, State, Zip :		
Employer's Name :		
Insurance Company :		
Address :		
City, State, Zip :		
Policy/Group # :		

I authorize Dr. Bacquet to release any and all medical or dental information to my insurance carriers for purposes of claims administration. I authorize Dr. Bacquet to share my health information with other health care providers for the purpose of care coordination. I authorize the use of my signature below for insurance claims administration and for my insurance company to pay directly to Dr. Bacquet insurance benefits otherwise payable to me. I understand that I am financially responsible for all treatment rendered that is not paid by my medical or dental insurance.

_____ _____

Signature of Patient, Parent, or Guardian Date

For Dental Office Use Only: ( ) Dental Materials Fact Sheet ( ) HIPAA Notice of Privacy Practices

Medical and Dental Health Information

Patient's Name _____ **Date of Birth** _____ **Age** _____

Please Circle "Yes" or "No" for Each Health Question and Fill in All of the Blanks. All Information is Confidential.

1) Are you in good health? ..... Yes No
If you answered "No" describe your health _____

2) Are you currently under the care of a physician? ..... Yes No
If "Yes" describe for what reason or condition _____
Physician's name & telephone _____

3) Have you had any surgery or serious illness? ..... Yes No
If "Yes" please describe _____

4) Please circle "Yes" or "No" for any condition or illness that you have had or have at present.

Yes No Heart Disease	Yes No H.I.V. Positive	Yes No Heart Murmur	Yes No Kidney Disease
Yes No Heart Attack	Yes No H.I.V. / A.R.C.	Yes No Congenital Heart Defects	Yes No Thyroid Disease
Yes No Heart Surgery	Yes No Anemia	Yes No Infective Endocarditis	Yes No Lung Disease
Yes No Stroke	Yes No Artificial Joints	Yes No Artificial Heart Valve	Yes No Tuberculosis
Yes No High Blood Pressure	Yes No Diabetes	Yes No Irregular Heart Rhythm	Yes No Liver Disease
Yes No Arteriosclerosis	Yes No Ulcers	Yes No Take Blood Thinners	Yes No Hepatitis
Yes No Angina Pectoris	Yes No Emphysema	Yes No Cancer	Yes No Psychiatric Care
Yes No Heart Pacemaker	Yes No Asthma	Yes No Radiation Therapy	Yes No Sinus Problems
Yes No Chest Pains	Yes No Glaucoma	Yes No Chemotherapy	Yes No Hearing Problems
Yes No Bleeding Problems	Yes No Dizzy Spells	Yes No Take Cortisone / Steroids	Yes No Severe Headaches
Yes No Bruise Easily	Yes No Arthritis	Yes No Epilepsy / Seizures	Yes No Osteoporosis
Yes No Back Problems	Yes No Rheumatism	Yes No Difficulty Breathing	Yes No Dental Implants

Yes No Jaw Joint Clicks, Pops, Locks , Pain Around Ears, Pain in Jaw Joint (If "Yes" Please Circle All Symptoms)
Yes No Take Bisphosphonates (e.g. Fosamax, Actonel, Boniva, Aredia, Zometa) If "Yes" for how long _____

5) Do you have any disease, condition, or health problem not listed above? ..... Yes No
If "Yes" describe the disease or health problem _____

6) Are you taking any medications or other chemical substances? ..... Yes No
If "Yes" list medications & condition being treated _____
_____
_____

7) Are you allergic to any medications or substances?..... Yes No
Please circle "Yes" or "No" for all allergies and list any additional allergies you are aware of.

Yes No Penicillin	Yes No Aspirin	Yes No Latex Rubber
Yes No Erythromycin	Yes No Tylenol	Yes No Local Dental Anesthetics
Yes No Tetracycline	Yes No Codeine	Yes No Allergic to Jewelry
Yes No Clindamycin	Yes No Acetaminophen	Yes No Allergic to any Metals
Yes No Amoxicillin	Yes No Sulfites	Yes No Allergic to Nickel Metal

Yes No Others (If Yes Please List) _____

8) Is there any other information the Doctor should know about your health? ..... Yes No
If "Yes" please provide information _____

9) Women Only : Are you pregnant, nursing, or taking oral contraceptives? (If "Yes"Circle)..... Yes No

To the best of my knowledge, all of the preceding answers are correct. If I ever have any change in my health, or if any of my medicines change, I will inform the Doctor at my next appointment without fail.

_____ _____ _____ _____
Signature of Patient, Parent, or Guardian Date Signature of the Reviewing Doctor Date