CHANELLE SY dds
GENERAL AND COSMETIC DENTISTRY
MISSION VIEJO (949) 380-0700

25212 Marguerite Pkwy, Suite 110 | Mission Viejo, CA 92692
(949) 380-0700 | sydentistry.com

Patient Information

Please complete all applicable fields. Fields marked * are required.

LEGAL NAME *

PREFERRED NAME

DATE OF BIRTH *

PRONOUNS (OPTIONAL)

OCCUPATION

STREET ADDRESS *

CITY *

STATE *

ZIP *

EMAIL

MOBILE PHONE *

OTHER PHONE

PREFERRED LANGUAGE

COMMUNICATION PREFERENCES

Choose how we may contact you about appointments, treatment, billing, and other health-care operations. Standard message and data rates may apply. You may change these preferences at any time.

☐ Phone call ☐ Voicemail ☐ Text/SMS ☐ Email ☐ Postal mail

SPECIFIC PRIVACY INSTRUCTIONS (FOR EXAMPLE, DO NOT LEAVE VOICEMAIL)

EMERGENCY CONTACT

NAME *

RELATIONSHIP

PHONE *

RESPONSIBLE PARTY AND INSURANCE

○ Patient ○ Someone else

RESPONSIBLE PARTY NAME (IF NOT PATIENT)

RESPONSIBLE PARTY DOB

RESPONSIBLE PARTY PHONE

ADDRESS IF DIFFERENT

DENTAL INSURANCE COMPANY

SUBSCRIBER'S EMPLOYER

SUBSCRIBER NAME

SUBSCRIBER DOB

MEMBER / ID NUMBER

GROUP NUMBER

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Medical History

Accurate information helps us provide safe dental care. Ask us privately about any question.

Mark Yes or No for each item. Explain any Yes answer where requested. Include prescription drugs, over-the-counter medicines, vitamins, supplements, injections, and infusions.

CURRENT CARE AND MEDICATIONS

Are you currently under the care of a physician or specialist? ○ Yes ○ No

PHYSICIAN/SPECIALIST NAME, SPECIALTY, PHONE, AND REASON

CURRENT MEDICATIONS, SUPPLEMENTS, INJECTIONS, AND DOSES *

MEDICATION, LATEX, FOOD, OR OTHER ALLERGIES AND REACTION *

MEDICATION AND TREATMENT CONSIDERATIONS

Do you take a blood thinner or antiplatelet medicine (for example, warfarin, apixaban, clopidogrel, or daily aspirin)? ○ Yes ○ No

Have you taken a bone-strengthening/antiresorptive medicine or infusion (for example, Fosamax, Prolia, Reclast, or Zometa)? ○ Yes ○ No

Do you take or have you recently taken a GLP-1 medicine (for example, Ozempic, Wegovy, Mounjaro, or Zepbound)? ○ Yes ○ No

Do you take long-term steroids, immunosuppressants, chemotherapy, or biologic medicines? ○ Yes ○ No

Have a physician or dentist advised antibiotic premedication before dental treatment? ○ Yes ○ No

Are you pregnant, possibly pregnant, trying to become pregnant, or breastfeeding? ○ Yes ○ No

PLEASE EXPLAIN YES ANSWERS, INCLUDING MEDICATION NAME AND DATES

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Health Conditions

For each condition, select Yes or No. Add details at the bottom of the page.

Heart attack, heart failure, angina, or other heart disease	Yes	No
Pacemaker, implanted defibrillator, artificial heart valve, or heart surgery	Yes	No
Heart murmur, mitral valve prolapse, rheumatic fever, congenital condition, or endocarditis	Yes	No
High or low blood pressure	Yes	No
Stroke, TIA, blood clot, or vascular disease	Yes	No
Bleeding/clotting disorder, anemia, blood transfusion, or easy bruising	Yes	No
Diabetes or blood-sugar problem	Yes	No
Kidney disease, liver disease, hepatitis, or jaundice	Yes	No
Asthma, COPD, sinus disease, breathing difficulty, or tuberculosis	Yes	No
Sleep apnea, CPAP use, or significant snoring	Yes	No
Seizures, fainting, neurologic disorder, or head injury	Yes	No
Thyroid, adrenal, or other endocrine disorder	Yes	No
Immune disorder, HIV, HPV/STI, recurrent infection, or MRSA	Yes	No
Cancer, chemotherapy, radiation, or transplant	Yes	No
Artificial joint, prosthesis, or implanted medical device	Yes	No
Acid reflux, ulcer, eating disorder, or gastrointestinal disease	Yes	No
Arthritis, osteoporosis, or autoimmune disease	Yes	No
Anxiety, depression, or another mental health concern relevant to care	Yes	No
Alcohol, nicotine, cannabis, opioid, or other substance use that may affect care	Yes	No
Glaucoma, chronic fatigue, or any other condition, symptom, or disability	Yes	No

DETAILS FOR YES ANSWERS (CONDITION, DATES, TREATING CLINICIAN, AND CURRENT STATUS)

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Dental History

Tell us what matters most to you and about your previous dental care.

DENTAL HEALTH AND COMFORT

Do you currently have dental pain, swelling, or an urgent concern?	Yes	No
Are any teeth sensitive to temperature, sweets, biting, or pressure?	Yes	No
Do your gums bleed, feel tender, or have you noticed bad breath or recession?	Yes	No
Have you noticed loose teeth, food trapping, or a change in your bite?	Yes	No
Do you clench or grind, or wake with jaw pain or headaches?	Yes	No
Do you have jaw clicking, locking, limited opening, or pain near the ear/face?	Yes	No
Has anyone reported that you snore, stop breathing, or gasp during sleep?	Yes	No
Have you had a difficult dental experience or significant dental anxiety?	Yes	No

PLEASE EXPLAIN YES ANSWERS AND IDENTIFY LOCATION(S)

PRIMARY REASON FOR TODAY'S VISIT AND GOALS FOR YOUR SMILE/HEALTH

LAST DENTAL VISIT / CLEANING

PREVIOUS DENTIST AND CITY

PREVIOUS DENTAL CARE

Do you generally receive routine dental examinations and cleanings?	Yes	No
Have you had orthodontic treatment or worn a retainer?	Yes	No
Have you had extractions/oral surgery, implants, gum treatment, or a nightguard/bite appliance?	Yes	No

PLEASE EXPLAIN PRIOR TREATMENT OR APPLIANCES

HOW DID YOU HEAR ABOUT US?

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Acknowledgments & Signatures

Review the office terms, confirm your health history, and sign.

RECENT HEALTH EVENTS

In the past two years, have you been hospitalized, had surgery, or received emergency care? ○ Yes ○ No

Have you had a serious reaction or complication from medical or dental treatment or anesthesia? ○ Yes ○ No

DATES AND DETAILS

OFFICE AND FINANCIAL ACKNOWLEDGMENTS

Appointments: We reserve time specifically for you. Please give at least 48 hours (two business days) notice when changing an appointment. A late-cancellation or missed-appointment fee may apply under the office's current written policy.

Payment and insurance: I understand I am responsible for charges for services provided to me or my dependent, except as limited by an applicable contract or law. Insurance estimates are not guarantees of payment. I authorize submission of claims and direct payment of benefits to the practice when permitted. Any finance charge or collection cost will be imposed only as allowed by law and disclosed in the practice's current financial policy.

Consent to care: I authorize examinations, diagnostic records, preventive care, and routine treatment that I agree to after discussion. I understand that procedure-specific risks, benefits, alternatives, and costs will be discussed when applicable, and that I may ask questions or withdraw consent before treatment. This acknowledgment does not replace procedure-specific informed consent.

Information use: I authorize use and disclosure of health information for treatment, payment, and health-care operations as permitted by law and described in the Notice of Privacy Practices. Optional public use of photos or testimonials requires a separate authorization.

By signing, I confirm that I have reviewed this form, the information is complete and accurate to the best of my knowledge, and I will tell the practice about changes. I understand the dentist will review my health history with me.

PATIENT / PARENT / LEGAL REPRESENTATIVE SIGNATURE (TYPE OR SIGN AFTER PRINTING) * **DATE ***

IF SIGNED BY REPRESENTATIVE: NAME, RELATIONSHIP, AND AUTHORITY

DENTIST REVIEW / SIGNATURE **DATE**