dr. mark t. galli, d.d.s.

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Suite B-207
Encinitas, CA 92024
(760) 943-1449
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Patient Information

Patient's Name: _____ Male ☐ Female ☐ Birthdate: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Email Address: _____ Social Security # _____ Home Ph ( ) _____

Name of spouse, if applicable: _____ Cell Ph ( ) _____

Employer: _____ Occupation: _____

Business Address: _____ Work Ph ( ) _____

Who may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone ( ) _____

Party Responsible for Payment of Account

Party Responsible for Payment of Account: _____ Relationship to Patient: _____

Address: _____ Home Phone ( ) _____

Social Security # _____ Age: _____ Birthdate: _____

Employer: _____ Occupation: _____

Employer's Address (if different than above): _____

Do you have Dental Insurance? ☐ Yes ☐ No Work Phone ( ) _____

Dental History

Reason for this visit: _____

Previous dentist: _____ Date last treated: _____ Date of last dental x-rays: _____

YES	NO		YES	NO	
☐	☐	Have you ever had orthodontic treatment?	☐	☐	Have you ever experienced clicking of the jaw or pain in the joint?
☐	☐	Have you ever had periodontal (gum) treatment?	☐	☐	Do you have frequent headaches or neck pain?
☐	☐	Have you noticed any loosening of your teeth?	☐	☐	Do you clench or grind your teeth while awake or asleep?
☐	☐	Does food frequently become caught between your teeth?	☐	☐	Are you unhappy with the appearance of your teeth?
☐	☐	Do you have fear or anxiety related to dental treatment?			
☐	☐	Do your gums often bleed when you brush you teeth?			
☐	☐	Do you use tobacco?			
☐	☐	If yes, are you interested in stopping?			

Consent

The undersigned hereby authorizes doctor to take radiographs, study models, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with this patient, and further authorize and consent that doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize the doctor to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to other health practitioners. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, and are due and payable at the time services are rendered, unless previous arrangements have been made.

_____ _____

Signature (Patient/Responsible Party) Date

CONFIDENTIAL THANK YOU FOR YOUR COOPERATION IN SUPPLYING THE ABOVE INFORMATION

FOR OFFICE USE _____ _____ _____ _____

UPDATES (date & sign) _____ _____ _____ _____

Medical History

Name of Physician: _____ City: _____ Phone (___) _____

Date of last medical exam: _____ Are you pregnant? ☐ No ☐ Yes (Due date: _____)

Are you currently receiving medical care? ☐ No ☐ Yes If yes, reason: _____

Have you ever had or do you have any of the following? (Please check YES or NO)

YES	NO		YES	NO	
☐	☐	Hepatitis, liver disease, jaundice	☐	☐	Lung trouble (TB, asthma, emphysema)
☐	☐	Rheumatic fever	☐	☐	Arthritis
☐	☐	Diabetes	☐	☐	Fainting spells, epilepsy, convulsions
☐	☐	High or low blood pressure	☐	☐	Psychological disorders
☐	☐	Heart problems, type: _____	☐	☐	Tumor or cancer
☐	☐	Heart murmur	☐	☐	Prosthetic joint replacement
☐	☐	Shortness of breath	☐	☐	Sexually transmitted disease
☐	☐	Stroke, when: _____	☐	☐	AIDS or HIV infection
☐	☐	Blood trouble, anemia, leukemia	☐	☐	Temporal Arteritis
☐	☐	Excessive bleeding requiring treatment	☐	☐	Taken prescription drugs Fen-Phen, Redux or other weight loss meds
☐	☐	Cardiac Pacemaker			
☐	☐	Glaucoma	☐	☐	History of substance abuse
☐	☐	Major operation _____			

Are you now taking medicines for: (Please specify medication)

YES	NO		YES	NO	
☐	☐	Pain _____	☐	☐	Alcohol or Drug Abuse _____
☐	☐	Nerves (tranquilizers) _____	☐	☐	Headaches _____
☐	☐	Sleeping _____	☐	☐	Arthritis _____
☐	☐	Blood (thinners, other) _____	☐	☐	Allergy (Asthma) _____
☐	☐	Stomach (ulcer, other) _____	☐	☐	Birth Control _____
☐	☐	Thyroid _____	☐	☐	Other medications _____
☐	☐	Heart _____			_____

Have you ever shown an allergy to, been sick from, or been told not to use:

YES	NO		YES	NO	
☐	☐	Antibiotics (Penicillin, other)	☐	☐	Latex rubber
☐	☐	Narcotics (Codeine, other)	☐	☐	Other medications (please specify below)
☐	☐	Aspirin			_____
☐	☐	Metals (e.g. nickel, mercury, etc.)			_____
☐	☐	Anesthetic (Novocaine, other)			_____

Do you have any disease condition, or problem that is not mentioned above? _____

Would you like to speak to the doctor privately about any problem? ☐ Yes ☐ No _____