Grey J. Cunningham D.D.S.
7300 Girard Ave., Suite 206
La Jolla, CA 92037
(858) 454-4114

We would like to get to know you better!

Patient Name _____
Last First Middle
If Patient is a minor, state name of parent of legal guardian_____ Relationship _____
Residence Address _____
Street City Zip
Email Address _____ Fax Number _____
Mobile Number _____ Residence Number _____ Work Number _____
Social Security Number _____ Date of Birth _____ Drivers License Number _____
Employed by _____ How Long _____ Occupation _____
Business Address _____
Street City Zip
Marital Status _____ Spouse's Name _____ Spouse's Number _____

Emergency Contact Name _____Number _____

Insurance Information

Person responsible for this account _____ Relationship _____
Billing Address _____ Phone _____

Name of insurance company (Primary Insurance) _____
_____
Insured Persons Name Birth Date Relationship Social Security #
_____
Name of Group Dental Plan Group # Plan # Name of Union Local

Name of insurance company (Secondary Insurance) _____
_____
Insured Persons Name Birth Date Relationship Social Security #
_____
Name of Group Dental Plan Group # Plan # Name of Union Local

Are your teeth sensitive to	Yes	No		Yes	No
Heat?	❑	❑	Do you ever avoid any part of the mouth while brushing?	❑	❑
Cold?	❑	❑	Have you had a reaction to local anesthetic?	❑	❑
Sweets?	❑	❑	Are you dissatisfied with your teeth & their appearance?	❑	❑
Does your food catch between your teeth?	❑	❑	Do you smoke?	❑	❑
Do your gums bleed when brushing?	❑	❑	Have you had any teeth removed/oral surgery?	❑	❑
Have you noticed any gum swelling around any teeth?	❑	❑	How long have these teeth been missing?	____ yrs	
Do you have an unpleasant taste or odor in your mouth?	❑	❑	Do you feel you will eventually wear artificial dentures?	❑	❑
Have you ever had dry mouth?	❑	❑	Have you ever had orthodontic treatment?	❑	❑
Do you have Dental Implants?	❑	❑	Do you have any dental fears ?	❑	❑

Problems of the Jaw:

When was your last dental appointment? _____

Clicking of the Jaw	❑	❑
Pain (Joints. Ear, side of face)	❑	❑
Difficulty opening or closing	❑	❑
Difficult chewing	❑	❑

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	YES	NO
Are you in good general health?	❑	❑
Are you being treated for any illness now?	❑	❑

If yes, please describe: _____

Your Physician's Name _____ Address _____ Phone _____

Are you taking medications, drugs or pills now?	❑	❑

If yes, please describe: _____

Are you aware of having allergic reactions to any medication or substances? Penicillin, sulfa, codeine?	❑	❑

If yes, please describe: _____

Have you been hospitalized during the past five years?	❑	❑

If yes, please describe: _____

Indicate which of the following you have had, or have at present

	YES	NO		YES	NO		YES	NO
Heart Disease, Surgery, Attack	❑	❑	Swollen Ankles	❑	❑	Cancer	❑	❑
Heart Defect	❑	❑	Fainting, Dizzy Spells	❑	❑	Chemotherapy	❑	❑
Artificial Heart Valve	❑	❑	Stroke	❑	❑	Tumors	❑	❑
Heart Murmur	❑	❑	Diet	❑	❑	Venereal Disease	❑	❑
Congenital Heart Disease	❑	❑	Kidney Trouble	❑	❑	A.I.D.S	❑	❑
Mitral Valve Prolapse	❑	❑	Ulcers	❑	❑	H.I.V. Positive	❑	❑
Rheumatic Fever	❑	❑	Diabetes	❑	❑	Fever Blisters	❑	❑
High Blood Pressure	❑	❑	Thyroid Problems	❑	❑	Cold Sores	❑	❑
Chest Pain	❑	❑	Glaucoma	❑	❑	Blood Transfusion	❑	❑
Heart Pacemaker	❑	❑	Contact Lenses	❑	❑	Hemophilia	❑	❑
Artificial Joints	❑	❑	Hay Fever	❑	❑	Sickle Cell Disease	❑	❑
TB, Emphysema	❑	❑	Latex Sensitivity	❑	❑	Bruise Easily	❑	❑
Chronic Cough	❑	❑	Allergies or Hives	❑	❑	Liver Disease	❑	❑
Asthma	❑	❑	Sinus Trouble	❑	❑	Yellow Jaundice	❑	❑
Arthritis, Rheumatism	❑	❑	Hepatitis	❑	❑	Epilepsy, Seizures	❑	❑
Cortisone Medication	❑	❑	Radiation Therapy	❑	❑	Bisphosphonates	❑	❑
Psychiatric, Psychological Care	❑	❑	Diet Drug Use (Phen-Fen, Rudux, Pondium				❑	❑
Recreational Drugs	❑	❑	If yes, how much? _____					
Alcohol	❑	❑	If yes, how much? _____					

Have you lose or gained more that 10 pounds in the past year?	❑	❑
Do you have or have you had any disease, condition or problem not listed?	❑	❑

If yes, please describe: _____

Women	YES	NO		YES	NO		YES	NO
Are you pregnant?	❑	❑_____ Months	Are you nursing?	❑	❑	Are you taking birth control?	❑	❑

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature of Patient (Parent If Minor) _____ Date _____ Dr_____

Signature of Patient (Parent If Minor) _____ Date _____ Dr_____

Signature of Patient (Parent If Minor) _____ Date _____ Dr_____

I have read the Materials Fact Sheet by the Dental Board of California.

Signature of Patient (Parent If Minor) _____ Date _____