



About You

Today's Date: Patient's Name (Mr. Mrs. Ms. Dr.) Nickname: SS#: Birthday: Gender: Male Female Marital Status: Home Address: City: State: Zip Code: Home Phone: Work Phone: Cell Phone: E-mail Address: Whom may we thank for referring you? Other family members seen by us: Whom may we notify in case of an emergency? Phone: Relation:

Dental History

Referring Dentist (if applicable): Date of last dental visit: Your Previous Dentist: City: How long?: My current dental health is: Good Fair Poor Date of last professional dental cleaning?: # cleanings per year: Date of last full set of x-rays?:

What brings you here today?

PREVIOUS DENTAL HISTORY:

Do you or have you had any of the following?

- a. Head or neck injuries..... Yes No
b. Sore or sensitive teeth..... Yes No
c. Bleeding gums..... Yes No
d. Clenching or tooth grinding habit..... Yes No
e. Difficulty Chewing..... Yes No
f. Anxiety towards dental treatment..... Yes No
g. Orthodontic treatment..... Yes No
h. Periodontal treatment (deep cleanings)..... Yes No
i. Trouble opening/closing your jaw..... Yes No
j. Bleeding/slow healing after an extraction.. Yes No
k. Dissatisfaction with your smile..... Yes No

Medical History

Are you currently under the care of a physician? Yes No Date of last medical visit: Physician's Name: Address: Phone: My current health is: Good Fair Poor Pharmacy name: City: Phone: Current Height: Weight: Blood Pressure: Do/Did you smoke? Yes No How many packs/day? For how many years? Quit? When:

WOMEN:

Are you taking Birth Control? Yes No
Are you Pregnant? Yes No
a. If yes, How many weeks?
If you're postpartum, are you nursing? Yes No

Signature: Date: Reviewed By:



Medical History Continued

ALLERGIES:

Have you had any allergic reactions to:

- a. Aspirin..... Yes No
b. Penicillin..... Yes No
c. Erythromycin..... Yes No
d. Tetracycline Yes No
e. Sulfa Drugs Yes No
f. Codeine Yes No
g. Sedatives, sleeping pills (barbiturates) Yes No
h. Dental anesthetic Yes No
j. Latex gloves Yes No
k. Other: _____ Yes No

MEDICATIONS:

Are you taking any of the following?

- a. Acetaminophen..... Yes No
b. Antibiotics..... Yes No
c. Antihistamines..... Yes No
d. Aspirin..... Yes No
e. Blood Thinners..... Yes No
f. Blood Pressure Medication..... Yes No
g. Digitalis/Heart Medication..... Yes No
h. Insulin/Diabetes Drugs..... Yes No
i. Nitroglycerin..... Yes No
j. Recreational Drugs..... Yes No
k. Steroids/Cortisone..... Yes No
l. Thyroid Medicine..... Yes No
m. Tranquilizers..... Yes No

Have you ever taken IV or Oral Bisphosphonates

- (ie. Fosamax, Boniva, Actonel? Yes No
a. If yes, for how long? _____
b. Name of Bisphosphonate: _____

Please list all medications: (Continue below if additional space needed)

- a. _____ Dosage: _____
b. _____ Dosage: _____
c. _____ Dosage: _____
d. _____ Dosage: _____
e. _____ Dosage: _____
f. _____ Dosage: _____

Please elaborate on any medical conditions or additional medications: _____

MEDICAL CONDITIONS:

Do you or have you had any of the following?

- a. Abnormal Bleeding..... Yes No
b. Alcohol/Substance Abuse..... Yes No
c. Anemia..... Yes No
d. Arthritis..... Yes No
e. Artificial Heart Valves..... Yes No
f. Artificial Joints..... Yes No
g. Asthma..... Yes No
h. Blood Transfusion..... Yes No
i. Cancer..... Yes No
j. Chemotherapy..... Yes No
k. Congenital Heart Defect..... Yes No
l. Diabetes..... Yes No
m. Emphysema..... Yes No
n. Epilepsy..... Yes No
o. Glaucoma..... Yes No
p. Headaches..... Yes No
q. Heart Problems..... Yes No
r. Heart Murmur..... Yes No
s. Hemophilia..... Yes No
t. Hepatitis (A / B / C / D (circle) Yes No
u. Herpes..... Yes No
v. High Blood Pressure..... Yes No
w. Immune Deficiency Syndrome (HIV/AIDS) Yes No
x. Jaundice..... Yes No
y. Kidney Problems..... Yes No
z. Liver disease..... Yes No
aa. Low Blood Pressure..... Yes No
bb. Psychiatric Treatment..... Yes No
cc. Radiation Treatment..... Yes No
dd. Rheumatic fever..... Yes No
ee. Scarlet Fever..... Yes No
ff. Stroke..... Yes No
gg. Thyroid or parathyroid disorders..... Yes No
hh. Tuberculosis..... Yes No
ii. Ulcers..... Yes No

I affirm that the information in the health history I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature: _____ Date: _____ Reviewed By: _____

Insurance Profile

Name of insured: _____ Relation to patient: _____ SS#: _____ Insured's B-day: _____
Insured's employer: _____ Employer address (city, state, zip): _____
Insurance Co.: _____ Insurance Co. Phone #: _____ Group/Plan #: _____
Insurance Co. Address (city, state, zip): _____

SECONDARY INSURANCE:

Name of insured: _____ Relation to patient: _____ SS#: _____ Insured's B-day: _____
Insured's employer: _____ Employer address (city, state, zip): _____
Insurance Co.: _____ Insurance Co. Phone #: _____ Group/Plan #: _____
Insurance Co. Address (city, state, zip): _____

Authorizations

INSURANCE ASSIGNMENT RELEASE:

I hereby authorize my insurance company to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. My consent shall remain in effect until cancelled in writing. Initials _____

HIPAA and DENTAL MATERIAL FACT SHEET:

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I have reviewed/received a copy of the Dental Board of California Dental Material Fact Sheet. Downloadable copies are available online or in our office for your review. Initials _____

Financial Policies

Payment is always due at the time of service. Insurance benefits provided by this office are estimates. These benefits are based on the contract between the insurance company and the employer. I understand that any balance remaining regardless of insurance is the patient or guardians' responsibility.

For your convenience, we accept all major credit and debit cards.

Fees will be assessed for the following:

Table with 2 columns: Fee Description and Amount. Rows include Broken Appointments (\$75), Returned Check (\$35), Late Cancellation (less than 48 hours) (\$75), Finance Charge for outstanding balances 60 days or older (1.5% per month), and Collection fees (35% of balance sent to collection agency).

I acknowledge that I have read and understand the financial policy above. I agree that I am responsible for all fees and services rendered. I accept full financial responsibility for all charges not covered by insurance.

Signature: _____ Date: _____