

GETTING TO KNOW YOU AS OUR PATIENT

© Sugarman Dental – Porter Ranch, CA

Today's Date:		
PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE
Home Address	City, State, Zip Code	Birthdate
Marital Status Single Married Divorced Separated	Male <input type="checkbox"/> Female <input type="checkbox"/>	Drivers License and State
Primary Insurance Company _____ Group _____ Subscriber _____		
Secondary Insurance Company _____ Group _____ Subscriber _____		

RESPONSIBLE PARTY

NAME	SOCIAL SECURITY NUMBER	HOME PHONE
Home Address	City, State, Zip Code	Birthdate
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone
Business Address	City	State Zip Code
Spouse's Name	Social Security Number	Birthdate
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City	State Zip Code

How did you hear about our Office?

(check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office? _____

Referred by a friend Relative Insurance Plan Sign By building Other _____

If you were referred, whom may we thank for referring you? _____

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. A processing fee of \$25.00 will be applied to any unpaid check returned for any reason.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 60 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

Your appointment time is reserved especially for you. Please notify us 48 hours in advance if any changes in your schedule occurs.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing.	Y N I have problems eating.
Y N I like my smile.	Y N I have had orthodontics.
Y N I prefer tooth-colored fillings.	Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.	Y N I want my teeth straight.
	Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? please circle Y for yes or N for no.

1. Y N Heart Disease	22. Y N Liver Disease	Doctor Notes Only:
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice	
3. Y N Stroke	24. Y N Hepatitis Type_____	
4. Y N Congenital Heart Lesions	25. Y N Diabetes	
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst	
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)	
7. Y N Anemia	28. Y N Herpes	
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis	
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease	
10. Y N Asthma	31. Y N Kidney Disease	
11. Y N Hay Fever	32. Y N Tumor or Malignancy	
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy	
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment	
14. Y N Ulcers	35. Y N History of Drug Addiction	
15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other	36. Y N AIDS	
16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____	37. Y N Immune Suppressed Disorder	
17. Y N I have consumed alcohol within the last 24 hours.	38. Y N Hearing Loss	
18. Y N I usually take an antibiotic prior to dental treatment.	39. Y N Fainting Spells	
19. Y N Have you ever taken Fen-Phen or Redux?	40. Y N Glaucoma	
20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____	41. Y N History of Emotional or Nervous Disorders	

21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

<p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p>Please list all medications you are currently taking:</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date