

Welcome to Aliso Creek Dental

Patient Information

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

Today's Date: _____

Patient's Name _____ Age _____ **D.O.B** _____ M _____ F _____

If Patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ For how long? _____ Own _____ Rent _____
Street City Zip

Patient is: Married _____ Single _____ Divorced _____ Separated _____ Widowed _____ Minor _____ Email _____

Driver License No. _____ Social Security No. _____ Res. Phone (_____) _____

Employed by _____ How Long? _____ Cell Phone (_____) _____

Business Address _____ Bus. Phone (_____) _____

Spouse Name _____ Driver License No. _____ Soc. Sec No. _____

Employed By _____ How Long? _____ Occupation _____

Business Address _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Res. Phone (_____) _____
Street City Zip

Name of Physician _____ (_____) _____ I have no Physician
Street City Zip Telephone

Former Dentist _____ (_____) _____
Street City Zip Telephone

Why are you changing dentists? _____ Do you wish to talk to the doctor privately? _____

Is this office visit for Emergency Dental Care? _____ Yes _____ No if yes, explain: _____

School Children Attend _____ **whom may we thank for referring you?** _____

Financial Information

Person responsible for this account _____ Relationship _____ (_____) _____
Telephone

Address _____ (_____) _____
Street City Zip Cell Phone

Preference of Payment: _____ Cash on day of treatment _____ Visa No. _____ Exp _____
MasterCard No. _____ Exp _____

Name of Insurance Company (primary Insurance) _____ Insured Persons Name _____

Relationship _____ Birth date _____ Social Security _____

Name of group Dental Plan _____ Group No. _____ Plan No. _____

Terms & Conditions

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each payment must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangement must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance company's and will credit such collections to my account. However, this dental office cannot render service on the assumption that charges will be paid by an insurance company.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 ½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for service rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable and/or collection fees.

I grant my permission to you, or your assigns, to telephone mw at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: _____ Date: _____

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health. Please answer each question. Circle the appropriate box YES or NO where applicable.

Medical History

1. Are you in good health? Yes _____ No _____
 2. Date of last physical examination Yes _____ No _____
 3. Are you now under the care of physician? Yes _____ No _____
 4. Have you ever had any serious illness or operation Yes _____ No _____
 If so what illness or operation? _____
 5. Have you ever been hospitalized? Yes _____ No _____
 If so what was the problem? _____
 6. Are you taking any _____ medications _____ drugs _____ herbs? Yes _____ No _____
 If so, what? _____ what dosage? _____
 7. Are you using any recreational drugs (marijuana, cocaine, etc.)? _____ Yes _____ No if so what? _____
 8. Have you ever been pre-medicated with antibiotics for your dental treatment? Yes _____ No _____
 9. Are you sensitive or allergic to any drugs or materials?
 _____ Penicillin; _____ Tetracycline; _____ Sulfa Drugs; _____ Aspirin; _____ Codeine; _____ Latex; _____ Other Yes _____ No _____
 10. Do you have or had any of the following: (Please check Y for Yes or N for No- answer all conditions)

- | | | | |
|---------------------------|---------------------------|-------------------------------------|---|
| Y N Aids | Y N Difficulty Swallowing | Y N Kidney Disease | Y N Sleep Apnea |
| Y N Allergies or hives | Y N Drug Addiction | Y N Joint Replacement | Y N Snoring |
| Y N Allergies to metal | Y N Emphysema | Y N Liver Disease | Y N Stomach Ulcers |
| Y N Anemia | Y N Epilepsy or Seizures | Y N Mental Disorder | Y N TMJ (Temporomandibular Joint) disorder |
| Y N Angina Pectoris | Y N Excessive Bleeding | Y N Mitral Valve Pressure | |
| Y N Arthritis | Y N Fainting Spells | Y N Nervous Disorder | Y N Tonsillitis |
| Y N Artificial Prosthesis | Y N Glaucoma | Y N Osteoporosis | Y N Tuberculosis |
| Y N Asthma | Y N Hay Fever | Y N Pain in jaw joints | Y N Tumors or Growth |
| Y N Blood Disease | Y N Headaches | Y N Psychiatric Treatment | Y N Thyroid Disease |
| Y N Blood Transfusion | Y N Head Injuries | Y N Radiation Treatment of any Kind | Y N Venereal Disease (Syphilis, Gonorrhoea) |
| Y N Bruise Easily | Y N Heart Aliments | | Y N Ulcers |
| Y N Cancer | Y N Heart Attack | Y N Respiratory Disease | Y N X-Ray or Cobalt Treatment |
| Y N Cerebral Palsy | Y N Heart Failure | Y N Rheumatic Fever | Y N Hepatitis or Jaundice |
| Y N Chemotherapy | Y N Hemophilia | Y N Rheumatism | Y N Stroke |
| Y N Chicken Pox | Y N Herpes | Y N Scarlet Fever | Y N Other.... |
| Y N Cold Sores | Y N High Blood Pressure | Y N Seizures | |
| Y N Cortisone Medicine | Y N HIV related Complex | Y N Sickle Cell Disease | |
| Y N Diabetes | Y N Implant | Y N Sinus Trouble | |

11. Do you have any disease, condition or problem not listed that you think we should know about? Yes _____ No _____
 12. Do you wear a cardiac pacemaker, or have you had heart surgery? Yes _____ No _____
 13. Do you smoke? If yes, how much? _____ Cigarettes _____ Cigars _____ Pack Per Day Yes _____ No _____
 14. Have you ever taken drugs _____ Fen-Pen, _____ Redux or any _____ diet drugs? Yes _____ No _____
 15. (Women) are you Pregnant? If so how many months Yes _____ No _____
 16. (Woman) Do you have any problems associated with your menstrual period? Yes _____ No _____
 17. (Women) Do you take any birth control medication or hormones? Yes _____ No _____

Dental History

1. Have you ever had a local anesthetic (Novocain, etc.)? Yes _____ No _____
 2. Have you ever had any unfavorable reaction from a local anesthetic? Yes _____ No _____
 3. Have you ever had any serious trouble associated with any previous dental treatment? Yes _____ No _____
 4. How long since your last full mouth X-rays? _____ weeks _____ Months _____ years Yes _____ No _____
 5. How long since your last dental treatment? _____ weeks _____ Months _____ years Yes _____ No _____
 6. Does Dental Treatment make you nervous? _____ slightly _____ Moderately _____ Extremely? Yes _____ No _____
 7. Would you desire to be pre-sedated? Yes _____ No _____

_____ I hereby acknowledge I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. _____ Patient refused/ was unable to sign because _____

_____ I have received a copy of the DENTAL MATERIAL FACT SHEETS as required by law. To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any changes in my health or if my medication change, I will, without fail, inform the doctor at my next appointment.

Date: _____ Signature: _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge if the care of the patient whose name appears on this health history form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advised in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ Date: _____ Relationship to patient: _____