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_____Seperated_____Widoweed_____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 ____ I have no Physician
Name of 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
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 herby 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 entitles to recover all costs incurred including reasonable and/or collection fees.
I grant my permission to you, or your assigns, to telephone me 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 you r 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 _____
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 Anemia	**Y N** Implant	Y **N** Head Injuries	**Y N** Drug Addiction	**Y N** Blood Transfusion	**Y N** Excessive Bleeding	**Y N** Osteoporosis
Y N Herpes	**Y N** Headaches	**Y N** Heart Failure	**Y N** Kidney Disease	**Y N** Joint Replacement	**Y N** Mitral Valve Pressure	**Y N** X-Ray or Cobalt Treatment
Y N Glaucoma	**Y N** Scarlet Fever	**Y N** Chemotherapy	**Y N** Nervous Disorder	**Y N** High Blood Pressure	**Y N** Sinus Trouble	**Y N** Radiation Treatment of any Kind
Y N Ulcers	**Y N** Tonsillitis	**Y N** Stomach Ulcers	**Y N** Tumors or Growth	**Y N** Arthritis	**Y N** HIV related Complex	**Y N** Emphysema
Y N Diabetes	**Y N** Hemophilia	**Y N** Angina Pectoris	**Y N** Allergies or hives	**Y N** Respiratory Disease	**Y N** Aids	**Y N** Liver Disease
Y N Cold Sores	**Y N** Asthma	**Y N** Blood Disease	**Y N** Pain in jaw joints	**Y N** Epilepsy or Seizures	**Y N** Thyroid Disease	**Y N** Artificial Prosthesis
Y N Cancer	**Y N** Rheumatism	**Y N** Heart Aliments	**Y N** Sleep Apnea	**Y N** Psychiatric Treatment	**Y N** Fainting Spells	**Y N** Sickle Cell Disease
Y N Snoring	**Y N** Seizures	**Y N** Chicken Pox	**Y N** Heart Attack	**Y N** Rheumatic Fever	**Y N** Cortisone Medicine	**Y N** Difficulty Swallowing
Y N Hay Fever	**Y N** Bruise Easily	**Y N** Cerebral Palsy	**Y N** Tuberculosis	**Y N** Allergies to metal	**Y N** Mental Disorder	**Y N** Hepatitis or Jaundice
Y N Stroke	**Y N** Venereal Disease (Syphilis, Gonorrhea)			**Y N** TMJ (Temporomandibular Joint) disorder		**Y N** Other….

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

_____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 of 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:_____