DESERT DENTAL GROUP

General Dentistry | Cosmetic Dentistry | Endodontics | Oral Surgery | Orthodontics | Periodontics

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics from your physician before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had (periodontal) gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort jaw joint? (TMJ) ☐ Yes ☐ No

Do you wear partials or dentures? If yes, when were they place? _____ ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

How many times do you: Floss?_____ Brush?_____

Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No

Have you had any difficult extractions in the past? ☐ Yes ☐ No

Have you ever had any prolonged/abnormal bleeding following extractions? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last: Cleaning? _____ Dental Visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Smiles West we offer a wide variety of services to enhance and keep your smile beautiful.

REFERRAL SOURCE (WHO CAN WE THANK?)_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for any payments of services being rendered on my behalf or my dependents.

X_____

Signature of patient/guardian:

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PATIENT INFORMATION *(PLEASE FILL OUT COMPLETELY)*

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: ☐ Policy Holder ☐ Responsible Party ☐ Child

Address: _____ City, State and Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Birth Date: _____ Soc. Sec: _____ Driver Lic # _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Student Status: ☐ Full Time ☐ Part Time

School /Employer Name: Preferred Pharmacy/Phone:

PARENT/GUARDIAN INFORMATION *(For minors 17yrs & younger)*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State and Zip: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

Email Address: _____ Relationship to Patient: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self Employed ☐ Other Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

PRIMARY INSURANCE & SECONDARY INSURANCE (IF APPLICABLE, PLEASE FILL OUT COMPLETELY)

Name of Insured DOB: _____	Name of Insured DOB:
Insured ID/SSN: _____	Insured DOB: _____
Employer: _____	Employer: _____
Address: _____	Address: _____
City, State and Zip: _____	City, State and Zip: _____
Phone:	Phone:

I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit agencies. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that i am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. I understand that this dental practice is owned and operated by a independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Patient/Guardian:_____ Date:_____

PATIENT HEALTH HISTORY

Patient Name:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Fen-Phen? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

WOMEN, ARE YOU…

Pregnant/trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ARE YOU ALERGIC TO THE FOLLOWING…

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING…

AIDS/HIV Positive ☐ Yes ☐ No	Chronic Sinus Problems ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A, B, or C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Stomach Trouble ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Frequent Urination ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Press. ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Mental Retardation ☐ Yes ☐ No	Muscle Numbness ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Abnormal Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Cholesterol ☐ Yes ☐ No
Joint Replacement ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Muscle Weakness ☐ Yes ☐ No
Coronary Artery Blockage ☐ Yes ☐ No	Persistent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Thirst ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Respiratory Problems ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy/Radiation ☐ Yes ☐ No	TMJ or TMD ☐ Yes ☐ No	Dementia Disease ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Canker Sores ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Bruise Easily ☐ Yes ☐ No	Blood Disease ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Problems/Disease ☐ Yes ☐ No	Anxiety/Nervousness ☐ Yes ☐ No	Organ Transplant ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

IN CASE OF EMERGENCY CONTACT…

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN: _____ DATE: _____

MEDICAL HEALTH REVIEWED BY (DOCTOR): _____ DATE: _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Heath Insurance Portability and Accountability Act (HIPAA) require that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below acknowledging you have received these forms from this office.

1. A copy of the Dental Materials Fact Sheet; and
2. Notice of Privacy Practices.

_____

PRINT NAME OF PATIENT/PARENT/GUARDIAN

X _____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

_____

DATE

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____