

41011 California Oaks Rd • Suite 203 • Murrieta, CA 92562 • (951) 698-4888

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION

Name: LAST: _____ FIRST _____ M.I. _____ NICKNAME _____

Address: STREET _____

CITY _____ STATE _____ ZIP _____

DOB: _____ Male Female Social Security #: _____ - _____ - _____

If applicable, Spouse's Name: _____ Email: _____

Home (____) _____ Work (____) _____ Mobile (____) _____

Emergency Contact Name: _____ **Phone:** (____) _____

How would you like to receive appointment reminders? (Please circle): Phone Call Email Text

Employer: _____ May we contact you at work? Yes No

How did you hear about us? _____

DENTAL INSURANCE

Primary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone #: _____

Employer: _____ Group #: _____ Relation to patient: _____

Secondary Dental Carrier

Subscriber Name: _____ Social Security #: _____ DOB: _____

Insurance Co: _____ Insurance Phone #: _____

Employer: _____ Group #: _____ Relation to patient: _____

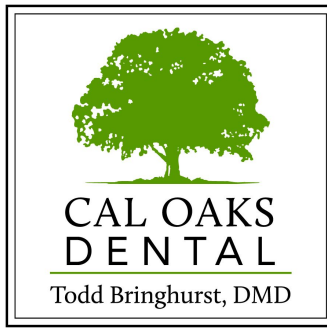
Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature: _____ Date: _____

If Patient is Under 18

Responsible Party: _____ Relation to Patient: _____



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Patient's Name: _____ Date: _____

HEALTH HISTORY

Check "Yes" or "No" to indicate if you have had any of the following conditions

Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF FEMALE	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many weeks? _____	
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICATIONS: (List any medications you	
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	are currently taking)	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Difficulty Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogren's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Drug/Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Facial Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	ALLERGIES		_____	
HIV/ AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metals	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____		_____	
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No			_____	

Patient's Signature: _____ Date: _____

If under 18 Parent/Responsible Party's Signature: _____

Doctor Review: _____



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DENTAL EVALUATION

Patient's Name: _____ Date: _____

Is there anything about your smile that you don't like? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing, biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you be interested in enhancing your smile with whiter, more aligned teeth? Yes No

If nervous, would you like to have your dentistry done with laughing gas (nitrous oxide)? Yes No

Is there anything about your mouth that concerns you now? Yes No

If yes, please explain: _____

When were you last seen at the Dentist? What treatment was done? _____

Were X-Rays taken at this last visit? Yes No

Have you ever had orthodontic treatment? Yes No

Do you use dental floss or toothpicks? Yes No

Have you ever had your wisdom teeth removed? Yes No

Do your gums ever bleed? Yes No

Are any of your teeth loose? Yes No

Do you have any swelling, sores or blisters in your mouth? Yes No

Have you ever been told that you have gum disease? Yes No

Have you ever visited a periodontist (gum specialist)? Yes No

Do you smoke? Yes No

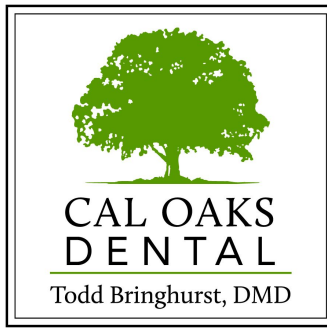
Do you feel you have unpleasant breath at times? Yes No

Are you interested in using sedatives while dental treatment is being performed? Yes No

How would you describe your dental health on a scale of 1-10 with 10 being the best? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant?

Is there anything that we can do to make your dental visits more comfortable? _____



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OFFICE POLICY

NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make every effort to keep your appointments. You must notify us within 48 hours if you need to reschedule or cancel your appointment. A \$250.00 deposit will be required to reserve an appointment for your surgery date. This fee will then be applied to dental work that is scheduled to be done.

PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that incurred due to a missed appointment.
- I received my insurance check and do not sent it to the office.

By signing this, I have read and understand the above policy.

Patient Signature

Date