COSMETIC AND GENERAL DENTISTRY

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Newport Beach, CA 92660

DATE: _____

PATIENT INFORMATION

Name _____ Birth date _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Social Security or ID Number _____ E-mail _____
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State ____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School/College _____ City _____ State ____
Who May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birth date _____
Employer _____ Work Phone _____
Currently a Patient in our Office? ☐Yes ☐No

INSURANCE INFORMATION

Name of Person Insured _____ Relation to Patient _____
Birth date _____ Social Security or ID # _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Loc # _____
Address _____ City _____ State _____ Zip _____
How Much Is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____
Secondary Insurance _____ Name of Insured _____ Phone _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____
Address _____
Date of last dental visit _____ Date of last dental X-rays _____

Check (√) If you have had any of the following:

☐Bad Breath	☐Grinding teeth	☐Sensitivity to heat
☐Bleeding gums	☐Loose teeth or broken fillings	☐Sensitivity to sweets
☐Clicking or popping jaw	☐Periodontal treatment	☐Sensitivity when biting
☐Food collection between teeth	☐Sensitivity of cold	☐Sores or growths in your mouth

HEALTH HISTORY

Physician's Name_____ Phone: _____ Date of last visit _____
Have you had any serious illnesses or operations? ☐Yes ☐No If yes, give approximate dates _____
Have you ever had a blood transfusion? ☐Yes ☐No
(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

	YES	NO		YES	NO		YES	NO		YES	NO
Aids	☐	☐	Cortisone Treatment	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐
Arthritis Rheumatism	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Cough up blood	☐	☐	HIV Positive	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Skin Rash	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Back Problems	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Swelling (Feet or Ankles)	☐	☐
Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Problems	☐	☐
Cancer	☐	☐	Headaches	☐	☐	Nervous Problems	☐	☐	Tobacco Habit	☐	☐
Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Heart Problems	☐	☐	Psychiatric Care	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Describe_____			Radiation Treatment	☐	☐	Ulcer	☐	☐
Latex Allergy	☐	☐	Hemophilia	☐	☐	Respiratory Disease	☐	☐	Venereal Disease	☐	☐

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request any insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance submissions.

Payment is due in full at time of treatment unless prior arrangements have been approved.

_____ _____ _____
Signature of Patient or parent if minor ***Dr. Initials*** ***Date***

DO NOT WRITE BELOW THIS LINE

Date _____ Signature _____ Date _____ Signature _____
Changes Health ☐No ☐Yes Changes Health ☐No ☐Yes

Date _____ Signature _____ Date _____ Signature _____
Changes Health ☐No ☐Yes Changes Health ☐No ☐Yes