PLEASE COMPLETE THE FOLLOWING

California Driver's License Number # (required info of financially responsible person)

__Dr. Last First Middle Birth date
__Mr.
__Mrs.
__Miss

Residence Address:

Number	Street	City	State	Zip	Area Code - Telephone

If less than one year, previous address:

Number	Street	City	State	Zip	Area Code - Telephone

Marital Status	Social Security #	Occupation	Employer

Address of Employer:

Number	Street	City	State	Zip	Area Code - Telephone

Name of Spouse	Spouse's Social Security #	Occupation	Employer

Name of person who is legally responsible:

Number	Street	City	State	Zip	Area Code - Telephone

By whom were you referred? When?

INSURANCE INFORMATION
If you have any type of dental Insurance, please complete the following. If not, turn the page.

Name of Insurance Carrier		
Name of Group Dental Plan		Group Number
Employee		Employee's Social Security Number
Patient	Relationship to Employee	Employee's Birth date

Employer

Number	Street	City	State	Zip	Area Code - Telephone

Has the patient had previous dental care under this plan?	When?

Is the patient covered by another plan? ___No ___Yes If yes, please complete the following relating to that plan.

Employer providing this additional plan		Name of insurance carrier
Employee working for this employer	Employee's Birth Date	Employee's Social Security #

Employer's Address:

Number	Street	City	State	Zip	Area Code - Telephone

Please be sure to obtain a copy of Office Policy regarding insurance programs

MEDICAL HISTORY

Family Physician _____ Specialty_____

Address _____
Number Street City State Zip Area and Phone

Height_____ Weight_____ Age_____ Date of last complete medical exam_____

Please circle yes or no. If yes, please fill in details.

Yes	No	Do you have a current medical problem? What?
Yes	No	Do you have heart trouble? What kind?
Yes	No	Have you had rheumatic fever? When?
Yes	No	Do you have high or low blood pressure? Is it controlled?
Yes	No	Have you had pains in the chest or shortness of breath?
Yes	No	Do your ankles ever swell?
Yes	No	Has your physician ever told you that you are anemic?
Yes	No	Have you ever had a stroke? When?
Yes	No	Have you ever had diabetes? How is it controlled?
Yes	No	Are you Subject to fainting or dizziness? When?
Yes	No	Do you have headaches? How often?
Yes	No	Do you have any nervous disorder? How is it controlled?
Yes	No	Do you take tranquilizers or sedatives? How often?
Yes	No	Are you allergic to any medication or latex?
Yes	No	Have you been advised not to take any medication? What?
Yes	No	Do you have asthma or hay fever? How is it controlled?
Yes	No	Have you ever had tuberculosis? When?
Yes	No	Have you ever had infectious hepatitis? When?
Yes	No	Do you have arthritis? How is it controlled?
Yes	No	Have you ever had a tumor or cancer? How was it treated?
Yes	No	Are you taking any medication?

Please list medications you are taking:

Taking	For	Taking	For
Taking	For	Taking	For
Taking	For	Taking	For
Taking	For	Taking	For

For Women

Yes	No	Are you pregnant? Expected delivery date

DENTAL HISTORY

Please circle yes or no. If yes, please fill in details.

Yes	No	Are you presently in any dental pain?
Yes	No	Have you ever experienced any unfavorable reaction to dentistry? What?
Yes	No	Have you lost any teeth? From what cause?
Yes	No	Have you ever had orthodontic treatment? When?
Yes	No	Do you have any growths or swellings in your mouth? How long have they existed?
Yes	No	Do your gums bleed when brushing your mouth?
Yes	No	Do you avoid brushing any part of your mouth? Why?
Yes	No	Have you ever been told you have pyorrhea? When?
Yes	No	Is any part of your mouth sensitive to temperature, pressure or food or drink? What?
Yes	No	Do you have a burning sensation of your mouth?
Yes	No	Have you ever had a bad reaction to a denial anesthetic? When?
Yes	No	Does food catch between your teeth?
Yes	No	Do you have any pain or soreness around your eyes or ears or other parts of your face? When?
Yes	No	Are you aware of Stiff neck muscles? How often?
Yes	No	Do you ever awaken with an awareness of your teeth or jaws? How often?
Yes	No	Are you aware of clenching your teeth during your daytime hours? How often?
Yes	No	Have you ever been told you grind your teeth during sleep? How often?
Yes	No	Are you aware of your jaw clicking or popping while eating or yawning? How often?
Yes	No	Do you have difficulty in opening your mouth widely?
Yes	No	Do you have an unpleasant taste or odor in your mouth?
Yes	No	Are you dissatisfied with your teeth and their appearance?
Yes	No	Do you feel you will eventually wear full artificial dentures?
Yes	No	Do any members of your family including your parents wear dentures?
Yes	No	Do you want to learn to control your dental disease and retain your teeth?
Yes	No	Are you deeply concerned about the finances required to return your mouth to excellent dental health?

Supplemental Denture History

For what reason were your teeth lost?
When did you receive your first partial or complete denture?
Approximate date of extractions:
Was your first complete denture placed the same day the teeth were extracted?
How many complete or partial dentures have you had? Upper_____ Lower _____
How long have you worn your present denture?
Has it been relined?
Your last denture was constructed by:
What is your present denture problem?
Are you satisfied with the appearance?
Are you satisfied with the comfort?
Are you satisfied with the chewing ability?
Do you wear your dentures 24 hours a day?_____ If not, why not?
Do you bite your tongue or cheek with your dentures?
Do your dentures click during speech?
Is your speech influenced by your dentures?_____ How ?
What do you expect of your new denture?

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility.

Signature_____ Date_____

Appointment Agreement

I understand that as a patient in this office I agree to pay $40 for any appointments I fail or break (your dental plan may have a lesser fee which will apply to you).

I understand that a failed appointment is one in which I do not show up for, or one that I show so late for that the doctor is unable to treat me due to insufficient time remaining in my scheduled appointment.

I understand that a broken appointment is one in which I do not provide at least 24 hours of notice of cancellation prior to the actual appointment time.

I further understand that the office is very strict on this and cancellation with anything less than 24 hours notice will result in a broken appointment fee regardless of my reason or excuse for breaking the appointment.

I also understand that this policy applies per person/per appointment, so multiple family members booked together will each be charged for failing or breaking their individual appointments, and that ultimately it is 100% my responsibility to remember the appointments made, and it is not the office's responsibility to remind me of those appointments.

I further understand that I am required to, and agree to, pay my copayment for all services the day they are rendered, and that failure to bring sufficient funds to the appointment to pay for those services can result in no treatment being rendered, and that the appointment will be considered broken and that I will be charged the above fee for breaking that appointment.

I have read the above appointment agreement and I understand and agree to its terms and conditions.

Patient Signature_____ Date_____