Welcome to Encino Aesthetic Dental Group

Please fill out the following confidential questions found on both the front and back of this page.

PATIENT INFORMATION

☐ Male ☐ Female

First Name_____ Last Name_____ Nickname _____

Age_____ Date of Birth_____ Social Security #_____ E-mail _____

Driver's License #_____ Who is responsible for this account? _____

Relationship to Patient_____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ yrs

Patient's Address_____
STREET CITY ZIP

Home Phone_____ Office Phone_____ Cell Phone _____

Occupation_____ Employer _____ How Long?_____

In case of emergency, contact: Name:_____ Relationship: _____ Phone_____

May we contact you at work? ☐ Yes ☐ No How did you hear about our office? _____

If you found our office through the Internet, what words did you ***Google***? _____

DENTAL INFORMATION

What is the primary reason for your visit today? _____

Is there anything about your teeth or smile that you would like to change? _____

Former Dentist_____ How long a patient? _____

Why are you leaving? _____

What did you like MOST about your last dentist? _____

Date of last cleaning_____ Date of last set of X-rays _____

DENTAL CONDITIONS (Please answer 'Yes' or 'No')

Bad Breath	☐ Yes	☐ No	Periodontal (Gum) treatment	☐ Yes	☐ No
Bleeding/Tender gums	☐ Yes	☐ No	Sensitivity to cold/hot drinks	☐ Yes	☐ No
Chewing on one side of mouth	☐ Yes	☐ No	Mouth Sores	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No	Wake up feeling tired	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No	Wake up with headaches	☐ Yes	☐ No
Tongue Piercings	☐ Yes	☐ No	Wake up with back/shoulder aches	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No	Teeth grinding at night	☐ Yes	☐ No

INSURANCE

Primary Dental Carrier_____ Group No. _____

Subscriber's Name _____ Soc. Sec. No._____ Date of Birth_____

Employer_____ Insurance Company _____

Insurance Phone No._____ Subscriber's relation to patient _____

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 patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, 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 companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby 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 the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by 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 services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's 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 the above conditions of treatment and agree to their content.

Signed _____ Date_____

HEALTH QUESTIONNAIRE

Please answer each question. Check the appropriate box and/or circle **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 a physician? ..... Yes No
   If so, what is the condition being treated? _____
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 or ☐ 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
   If Other, what drugs? _____
10. Do you have or have you had any of the following: (Please circle **"Y"** for **Yes** or **"N"** for **No** - answer all conditions):

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing
Y N Ulcers	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment of any kind
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N Acquired Immune Deficiency Syndrome (AIDS)
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ (Temporomandibular Joint) Disorder
Y N Headaches	Y N Scarlet Fever	Y N CHemotherapy	Y N Tumors or Growths	Y N Respiratory Disease	Y N Other _____
Y N Implant(s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures	_____

11. Do you have any disease, condition or problem not listed that you think we should know about? ..... Yes No
    If so, what? _____
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 ☐ Packs per day.....
14. Have you ever taken the drugs ☐ Fen-Phen ☐ Redux, ☐ Fosamax (Bisphosphonate), ☐ Zometa, ☐ Actonel, ☐ Boniva, ☐ Aredia, ☐ Diet Drugs? ... Yes No
15. (Women) Are you pregnant? If so how many months? ..... Yes No
16. (Women) 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 (Novocaine, etc.)? ..... Yes No
2. Have you ever had an unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain? _____
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely ..... Yes No
7. Would you desire to be pre-sedated? ..... 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 Materials Fact Sheet** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Ⓐ **Date** _____ **Signature** _____

Reviewed by _____ Lic # _____ Date _____

Ⓑ ***UPDATE - Since your last visit Ⓐ:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

_____

Date _____ **Signature** _____

Ⓒ ***UPDATE - Since your last visit Ⓑ:***

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in your medication? ..... Yes No
3. Have you had a change in your medical condition or had surgery? ..... Yes No

Please note changes in health since last visit. If no changes, please write "None"

_____

Date _____ **Signature** _____

Reviewed By	**DO NOT WRITE IN THIS SPACE**		
Ⓐ		Ⓐ	Ⓑ	Ⓒ
DATE _____	DATE	_____	_____	_____
Ⓑ	B.P.	___/___	___/___	___/___
DATE _____	PULSE	_____	_____	_____
Ⓒ	TEMP	_____	_____	_____
DATE _____	BY	_____	_____	_____

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

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 to perform such operations as may be deemed necessary or advisable 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:** _____ **Relationship to Patient** _____