

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor  
☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_  
\_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_



Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if  
any, otherwise payable to me for services rendered. I understand that I am  
financially responsible for all charges whether or not paid by insurance. I authorize  
the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

<u>Date</u>	<u>Relationship to Patient</u>
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Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext \_\_\_\_\_ Alt. Phone ( ) \_\_\_\_\_

Spouse's Work ( ) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Alt. Phone ( ) \_\_\_\_\_



Reason for today's visit _____	Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____	
	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### Women:

Are you pregnant? ☐ Yes ☐ No

Due date \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No



## Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_



## Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other \_\_\_\_\_

☐ Latex \_\_\_\_\_



## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**SAN DIMAS FAMILY & SEDATION DENTISTRY**  
**PRIVACY NOTICE**

The Practice...

1. is required by Federal Law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
2. under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.
3. is required to abide by the terms of this Privacy Notice.
4. reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI which it maintains.
5. will distribute any revised Privacy Notice to you prior to implementation.
6. will not retaliate against you for filing a complaint.

**EFFECTIVE DATE**

This notice is in effect as of 04/15/2003

**PATIENT ACKNOWLEDGEMENT**

PATIENT NAME: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**SAN DIMAS FAMILY & SEDATION DENTISTRY**  
**BROKEN APPOINTMENT POLICY**

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice, whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

- We allow for one (1) broken appointment within a 12-month period
- Any additional broken appointments within a 12-month period will be a fee of \$40.00.

Definition of "Broken Appointment": A broken appointment is when you:

- Cancel or reschedule an appointment with less than 24-hour notice
- Do not show up for your scheduled appointment
- Show up more than 15 minutes late to your scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

Thank you for your understanding and cooperation.

**PATIENT ACKNOWLEDGEMENT**

PATIENT NAME: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_