IMPORTANT

Please Read

In order to successfully submit these forms online it will require you to use the Adobe Acrobat Reader plugin for your web browser. If you do not have that you can click the link below and install it.

If you attempt to fill out these forms and submit them online using Adobe Acrobat Reader itself, or another similar utility, this will fail.

However, if you wish you can print out the forms using Adobe Acrobat Reader, or another similar utility, fill them out and bring them to your appointment.

Thank you for your cooperation.

Patient Information

Please take a moment to enter your information to help us ensure the quality of your care is excellent.

Title: (Mr., Mrs., Miss)
Last: **First:** **MI:**
Gender: ⦿ Male ○ Female **Family Status:** ⦿ Married ○ Single ○ Child

Birth Date: **Soc. Sec. #:** ___-___-____ **Previous Visit:**
Address:
Apt/Suite:
City:
State: CA **Zip Code:**
Email:
Home: **Cell:** **Work:** **Ext:**
Fax:
Other: **Best Time to Call:**

Whom may we thank for referring you to our practice?
Are other family member's patients here?
What in particular brings you to our office?

Method of Payment

Do you have dental insurance? ○ Yes ○ No

We are concerned about your dental health. We look forward to helping you with your dental care. Please remember that your dental insurance is your responsibility....but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept assignment of benefits from most insurance companies. This will reduce your immediate, out of pocket expenditures. The outlined estimate is based on limited information obtained from your insurance company.

Name of Insurance Company:
Name of Insured:
Date of Birth of Insured: SSN:
Company Name:
Do you have Dental Insurance coverage other than you own? ○ Yes ○ No
Name of Insurance Company:
Name of Insured:
Date of Birth of Insured: SSN:
Company Name:

Automatic Card Billing Authorization Form

As part of your billing protocol we have setup a convenient and automatic payment system. Simply fill out the information below and upon your approval, we will then automatically bill your credit/bank card for amounts due. Your total charge will appear on your monthly statement. You may cancel this billing at any time by contacting us.

Card Number: CVV: Expiration Date:

Medical Alerts

Do you have any Allergies?

☐ Allergies	☐ Anemia	☐ Arthritis/Rheumatism	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Chemical Dependency	☐ Chemotherapy	☐ Epilepsy
☐ Circulatory Problems	☐ Cortisone Treatments	☐ Cough, persistent or bloody	☐ Emphysema	☐ Diabetes
☐ Codeine Allergy	☐ Dizziness/Fainting	☐ Excessive Bleeding	☐ Glaucoma	☐ Growths
☐ Hay Fever	☐ Headaches	☐ Head Injuries	☐ Heart Disease	☐ Herpes
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ AIDS/HIV	☐ Jaundice
☐ Jaw Pain	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressu	☐ Mental Disorders
☐ Nervous Disorders	☐ Other	☐ Pacemaker	☐ Penicillin Allergy	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Skin Rash
☐ Sinus Problems	☐ Special Diet	☐ Shortness of Breath	☐ Swollen Feet	☐ Stroke
☐ Swollen Neck Glands	☐ Stomach Problems	☐ Thyroid Problems	☐ Tonsillitis	☐ Ulcers
☐ Tuberculosis	☐ Tumors	☐ Venereal Disease	☐ Weight Loss, Unexplained	

Are You Pregnant? ◯ Yes ◯ No If so, when are you due?

Are You Nursing? ◯ Yes ◯ No

Are You Taking Birth Control Pills? ◯ Yes ◯ No

Any other health problems that we should know about?

Medications

List any medications in which you are currently taking and the correlating diagnosis

Pharmacy Name and Number:

Dental History

Do you desire complete and thorough dental care or treatment of a specific problem only?

Have you had regular preventive dental care in the past? When?

Are your gums ever sore or do they bleed?

Have you ever been told you have gum disease? ◯ Yes ◯ No Do you clench or grind teeth? ◯ Yes ◯ No

Do you have sore or sensitive teeth? ◯ Yes ◯ No Sounds or pain in the jaw joint ◯ Yes ◯ No

Have you ever been told you have a problem with your bite? ◯ Yes ◯ No

Have you ever had a serious/difficult problem associated with any previous dental work?

Smile Evaluation

Do you like the way your teeth look? ◯ Yes ◯ No

Are you happy with the color of your teeth? ◯ Yes ◯ No

Would you like for your teeth to be straighter? ◯ Yes ◯ No

Do you have spaces between your teeth that you would like closed? If so, where?

Do you like the shape of your teeth? If not, why?

Do you have missing teeth that you would like replaced? ◯ Yes ◯ No

Do you have old silver fillings that you would like to replace with tooth colored fillings? ◯ Yes ◯ No

If you could change anything about your smile, what would you change?

Response Date:

Submit