DENTISTRY OF THOUSAND OAKS

PATIENT INFORMATION

Patient Name: ____________________________________ **Date of Birth:** ___/___/____ **Age:** _____

Patient is: MALE ☐ FEMALE ☐ **SSN#** ______/___/______

MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ MINOR ☐

If Patient is a minor give name of legal guardian: ____________________ **Relationship** ___________

Residence/ Address: ____

Home: ________________ **Cell:** ________________ **Work:** _______________

Email: ______________

Emergency Contact: _____________________ **Phone:** ______________ **Relationship:** ____________

Employed By: ______________________________________ **Phone:** ___________________________

Dental Insurance Co.: ________________________________

Insured's Name : _______________________ **Date of Birth:** ___________ **SSN# :** _____/___/______

Employed By: ______________________________________ **Relationship:** _____________________

Group Number: _____________________________________ **Contact:** ________________________

Name of Former Dentist: _____________________________ **Phone:** ___________________________

Name of General Doctor: _____________________________ **Phone:** __________________________

Why are you changing Dentists?: ____

Purpose of Appointment: ____

Is this office visit an Emergency Visit (Explain): ____

Who were you referred by: ____

AS A CONDITION OF THIS OFFICE, I UNDERSTAND FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THE PRACTICE DEPENDS UPON REIMBERSMENT FROM 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 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 DENTAL 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. OUR OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT S 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 DENTAL POLICY. A SERVICE CHARGE OF 1.5% PER MONTH (18% ANNUALLY) (BUT IN NO EVENT MORE THAN THE MAXIMUM RATE PERMISSABLE UNDER STATE LAW) WILL BE CHARGED ON THE UNPAID BALANCE ON ALL ACCOUNTS NOT PAID WITHIN 60 DAYS OF TREATMENT DATE. I UNDERSTAND THE FEES LISTED ON ANY AND ALL DENTAL CASES AND UNDERSTAND THEY CAN ONLY BE EXTENDED FOR A PERIOD OF 6 MONTHS FROM THE DATE OF THE PATIENTS EXAMINATION. IN CONSIDERATION OF THE PROFESSIONAL SERVICES RENDEREDTO ME OR AT MY REQUEST BY THE DOCTOR AND HIS STAFF, I AGREE TO PAY. THEREFORE 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 IN 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 COLLECTION FEES. I GRANT PERMISSION TO YOU OR YOUR ASSIGNEES TO TELEPHONE ME AT HOME OR AT MY WORK TO DISCUSS MATTERS RELATED TO THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND AGREE TO THEIR CONTENT.

SIGNED BY: ____ DATE: ___________

HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition , but they are all associated with proper healthcare.

Please answer each question. Check the appropriate box and/or circle YES or NO where applicable.

MEDICAL HISTORY4

1. Are you in good health? YES NO
2. When was your last physical examination? ______________________
3. Are you under the care of a physician? YES NO
   If so what is the condition being treated? ______________________
4. Have you ever had a serious illness or operation? ______________________YES NO
5. Have you been hospitalized? ______________________YES NO
6. Are you taking any medications? ______________________YES NO
7. Are you using any recreational drugs?______________________YES NO
8. Have you ever been pre-medicated with antibiotics for your dental health treatment? YES NO
9. Are you sensitive or allergic to any drugs or materials?______________________ YES NO
10. Do you have or have you ever had any of the following?
11. Do you have any disease or condition not listed that you think we should know about?______________________

Anemia	Y N	Heart Murmur	Y N	Hemophilia	Y N	Cortisone Medicine	Y N	Heart Ailments or Attack	Y N
Herpes	Y N	Liver Disease	Y N	Cold Sores	Y N	Allergies to Metals	Y N	Congenital Heart Lesions	Y N
Stroke	Y N	Blood Disease	Y N	Emphysema	Y N	Excessive Bleeding	Y N	X-Ray or Cobalt Treatment	Y N
Ulcers	Y N	Drug Addiction	Y N	Rheumatism	Y N	High Blood Pressure	Y N	Fainting Spells	Y N
Diabetes	Y N	Kidney Disease	Y N	Chicken Pox	Y N	HIV Related Complex	Y N	Chemotherapy	Y N
Glaucoma	Y N	Stomach Ulcers	Y N	Bruise Easy	Y N	Repertory Disease	Y N	Radiation Treatment of any kind	Y N
Arthritis	Y N	Angina Pectoris	Y N	Head Injuries	Y N	Epilepsy or Seizures	Y N	Venereal Disease (Syphilis or Gonorrhea)	Y N
Hay Fever	Y N	Mental Disorder	Y N	Heart Failure	Y N	Psychiatric Treatment	Y N	Aids	Y N
Tonsillitis	Y N	Cerebral Palsy	Y N	Scarlet Fever	Y N	Hepatitis or Jaundice	Y N	TMJ	Y N
Asthma	Y N	Thyroid Disease	Y N	Sinus Trouble	Y N	Difficulty in Swallowing	Y N	Cancer	Y N

12. Do you wear a cardiac pace maker or have you had heart surgery? YES NO
13. Do you smoke? YES NO
14. Have you ever taken drugs? YES NO
15. (Women) Are you pregnant ? YES NO
16. (Women) Are there any problems associated with your menstrual period? YES NO
17. (Women) Are you taking birth control medication or hormones? YES NO

DENTAL HISTORY

1. Have you ever had local anesthesia? (Lidocaine) YES NO
2. Have you ever had a bad reaction from local anesthesia? YES NO
3. Have you had any serious trouble associated wit any previous dental treatment YES NO
   If so please explain: ______________________
4. How long since your last X-Ray? WEEKS MONTHS YEARS
5. How long since your last dental exam? WEEKS MONTHS YEARS
6. Does dental treatment make you nervous? YES NO
7. Would you like to be sedated? YES NO

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

Date: ______________ Signature: ______________________

Consent for Treatment

I hereby grant authority to the dentist (s) in charge if 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 m anesthetics and/ or drugs. All services are rendered and accepted under the terms and conditions printed on the reverse thereof: 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 unable.

Signature: ______________________ Date: ______________ Relationship: ______________________