

ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Ph: _____ Work Ph: _____ Ext.: _____ Cell Ph: _____

Birth Date: _____ Soc. Sec.: _____ Driver's Lic.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Ins. Policy Holder ☐ Secondary Ins. Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Ph: _____ Work Ph: _____ Ext.: _____ Cell Ph: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Driver's Lic.: _____

Email: _____ ☐ I would like to receive correspondences via email

Section 2

Today's Visit reason: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Referred by: _____

Section 3

Occupation: _____

Business Address: _____

Business Phone: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State Zip: _____

Rem Benefits: _____ Rem. Deduct: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State Zip: _____

Rem Benefits: _____ Rem. Deduct: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State Zip: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If Yes: _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If Yes: _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If Yes: _____
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If Yes: _____ _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If Yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes: _____
Are you on a special diet?	☐ Yes ☐ No	If Yes: _____
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	If Yes: _____

Women, are you...:	Are you allergic to any of the following:
☐ Pregnant / Trying to get pregnant	☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Nursing ☐ Taking oral contraceptives	☐ Local Anesthetics ☐ Other: _____

Do you have, or have you had, any of the following:			
AIDS / HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Arthritis / Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells / Dizziness	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack / Failure	☐ Yes ☐ No
Cold Sores / Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble / Disease	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No
Herpes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No
Hypoglycemia	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No
Kidney Problems	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Pain in Jaw Joints	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Parathyroid Disease	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Radiation Treatments	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Recent Weight Loss	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Renal Dialysis	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Rheumatism	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Spina Bifida	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Stomach/Intestinal Disease	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swelling of Limbs	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Tumors or Growths	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Yellow Jaundice	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes: _____

Concent

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

This is to certify that I consent to the performing of whatever dental procedures may be decided upon to be necessary or advisable by One Dental Studio City. I hereby authorize One Dental Studio City to release any and all dental and medical information to insurance carrier(s) for the purpose of claims evaluation and processing. I hereby authorize my insurance carrier(s) to pay directly to One Dental Studio City the benefits otherwise payable to me. I hereby authorize One Dental Studio City to obtain my credit history. I understand that I am financially responsible for all charges. I authorize One Dental Studio City to use my photographs, x-rays, and other dental records for educational purposes. These authorizations remain valid until revoked in writing. I understand that each patient is unique and that dental treatment cannot be guaranteed. I will inform One Dental Studio City of any changes in my personal information.