Prospect Dental Care
Where Dentistry is our Passion

# GETTING TO KNOW YOU AS OUR PATIENT

Date

| Patient Name | Social Security Number | Driver's License and State | Birth date | Gender ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

| Home Address | City | State CA | Zip |
|---|---|---|---|
| | | | |

| Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ widowed | Email | Cell Number | Home Phone |
|---|---|---|---|
| | | | |

| Primary Insurance Company: | Group | Subscriber |
|---|---|---|
| | | |

| Secondary Insurance Company: | Group | Subscriber |
|---|---|---|
| | | |

## Responsible Party

| Name | Social Security Number | Home Phone |
|---|---|---|
| | | |

| Home Address | City, State, Zip | Birth date |
|---|---|---|
| | | |

| Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Relationship to patient | Driver's License and State |
|---|---|---|
| | | |

| Responsible Person's Employer | Occupation | Work Phone |
|---|---|---|
| | | |

| Business Address | City, State, Zip |
|---|---|
| | |

## Spouse's

| Spouse's Name | Social Security Number | Birth date |
|---|---|---|
| | | |

| Spouse's Employer | Spouse's Occupation | Spouse's Work Phone |
|---|---|---|
| | | |

| Spouse's Business Address | City, State, Zip |
|---|---|
| | |

## How do you hear about our office?

| | | | | |
|---|---|---|---|---|
| ☐ Referred by a Friend | ☐ Relative | ☐ Yellow Pages | ☐ Insurance Plan | ☐ Web Site |
| ☐ Other | ☐ Internet | ☐ Newspaper Ad | ☐ Direct Mailing | ☐ Sign By Building |

If you were referred, whom may we thank for referring you?

## Consent

I will answer all health questions to the best of my knowledge. *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

| Signature | Date | *Relationship to Patient* |
|---|---|---|
| | | |

## Agreement to pay

I agree to pay for all services rendered. In the event that payment is not made within thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to arid become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the-agreed upon fee schedule. Payment Preference

| ☐ Cash/Check on day of treatment | ☐ Credit Card | ☐ Debit Card |
|---|---|---|

| Signature | Date |
|---|---|
| | |

**There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.**

## Patient's Dental Health

Why have you come to see us today? (e.g.: checkup, consultation, etc.)

| Previous Dentist | Last Visit | Date of Last Cleaning |
|---|---|---|

Reasons for Changing Dentists:

Have you had any problem with past dental treatment?

Are you nervous about seeing a dentist? ☐ Yes ☐ No If Yeas, Please tell us why?

How Often do you brush? | Do you floss? How Often?

## Please Circle each that applies

| | | |
|---|---|---|
| ☐ I clench or grind by teeth during the day or while sleeping. | ☐ My gums bleed while brushing or flossing. | ☐ I like my smile. |
| ☐ I prefer tooth-colored fillings. | ☐ I avoid brushing part of my mouth due to pain. | ☐ My gums feel tender or swollen. |
| ☐ I have problems eating. | ☐ I have had orthodontics. | ☐ I have had a facial or jaw injury. |
| ☐ I want my teeth straightened | ☐ I want my teeth whiter. | |

What Are you dental priorities?
(e.g. appearance, dental health, etc.)

## Patient's Medical History

I consider my Health to be (please check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following?

| | | |
|---|---|---|
| ☐ 1. Heart disease | ☐ 22. Liver Disease | **Doctor Notes Only:** |
| ☐ 2. Heart Murmur/Mitral Valve Prolapse | ☐ 23. Jaundice | |
| ☐ 3. Stroke | ☐ 24. Hepatitis Type | |
| ☐ 4. Congenital Heart Lesions | ☐ 25. Diabetes | |
| ☐ 5. Rheumatic Fever | ☐ 26. Excessive Urination and/or Thirst | |
| ☐ 6. Abnormal Blood Pressure | ☐ 27. Infectious Mononucleosis ("Mono") | |
| ☐ 7. Anemia | ☐ 28. Herpes | |
| ☐ 8. Prolonged Bleeding Disorder | ☐ 29. Arthritis | |
| ☐ 9. Tuberculosis or Lung Disease | ☐ 30. Sexually Transmitted/Venereal Diseases | ☐ 36. AIDS |
| ☐ 10. Asthma | ☐ 31. Kidney Disease | ☐ 37. Immune Suppressed Disorder |
| ☐ 11. Hay Fever | ☐ 32. Tumor or Malignancy | ☐ 38. Hearing Loss |
| ☐ 12. Sinus Trouble | ☐ 33. Cancer/Chemotherapy | ☐ 39. Fainting Spells |
| ☐ 13. Epilepsy/Seizures | ☐ 34. Radiation/Therapy | ☐ 40. Glaucoma |
| ☐ 14. Ulcers | ☐ 35. History of Drug Addiction | ☐ 41. History of Emotional or Nervous Disorders |

☐ 15. Implants/Artificial Joints: Hip-Knee Other

☐ 16. I smoke or use chewing tobacco. If yes, how much per day? How many years?

☐ 17. I have consumed alcohol within the last 24 hours.

☐ 18. I usually take an antibiotic prior to dental treatment.

☐ 19. Have you ever taken Fen-Phen or Redux?

☐ 20. I have had major surgery. Year Type of operation

☐ 21. Do you have any other medical problem or medical history NOT listed on this form?

WOMEN

☐ 42. Are you taking birth control medication?

☐ 43. Are you or could you be pregnant?

☐ 44. Are you taking or ever taken Oral Bisphosphonate For Osteoporosis?

| Are Allergic to any of the following? | Please list all medications you are currently taking: | |
|---|---|---|
| ☐ 44. Aspirin/Ibuprofen | | |
| ☐ 45. Sulfa Drugs / Sulfites / Sulfides | | |
| ☐ 46. Penicillin | | |
| ☐ 47. Codeine | | |
| ☐ 48. Latex, Metals, Plastics | Physician's Name | Phone |
| ☐ 49. Local Anesthetics (Novocain) | Address | Fax |
| ☐ 50. Other Medications? Which ones? | | |

## In the event of an emergency, please contact:

| Name | Relationship | Phone |
|---|---|---|
| Name | Relationship | Phone |

| Medical Health Reviewed by: | Patient's Signature | Date |
|---|---|---|
| Doctor's Signature Date | If Patient is a Minor, Parent/Guardian Signature | Date |

RESET SUBMIT