Los Alamitos Dental Care
3551 Farquhar Avenue Suite 102
Los Alamitos, CA 90720
(562) 598-4111 • (714) 995-6611
General Dentistry

REGISTRATION and HEALTH HISTORY

Name of Patient _____ Date of Birth _____

Street Address _____ Phone ( ) _____

City _____ State _____ Zip _____

Cell Phone Number ( ) _____ email Address _____

Dr. ❑ Single ❑
Mr. ❑ Married ❑
Mrs. ❑ Domestic Partner ❑
Ms. ❑

Patient Employed by _____ City _____ Phone ( ) _____ ext _____

Occupation _____ Social Security Number _____ Driver's License Number _____

Name of Spouse _____ Spouse Employed by _____ Cell _____

Person Responsible for this Account _____ Relation to Patient _____ Dental Insurance? ❑ Yes ❑ No

How did you hear about our office? _____

MEDICAL HISTORY

Family Physician's Name _____ City _____ Phone ( ) _____

PLEASE CHECK any of the following which you have had OR have at present time:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease or Attack	❑	❑	Allergy to Local Anesthetic	❑	❑	Hepatitis/Liver Disease	❑	❑	Radiation/Chemotherapy	❑	❑
Angina Pectoris	❑	❑	Allergy to Any Medications	❑	❑	Tuberculosis	❑	❑	Bisphosphonates	❑	❑
Heart Murmur	❑	❑	_____			Epilepsy	❑	❑	Frequent Cold Sores	❑	❑
Mitral Valve Prolapse	❑	❑	Latex Allergy	❑	❑	Fainting or Dizzy Spells	❑	❑	Psychiatric Care	❑	❑
Rheumatic Fever	❑	❑	High Blood Pressure	❑	❑	Bleeding Problems	❑	❑	AIDS or HIV Positive	❑	❑
Artificial Heart Valve	❑	❑	Stroke	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Asthma	❑	❑
Heart Pacemaker	❑	❑	Emphysema	❑	❑	Kidney Trouble	❑	❑	Arthritis	❑	❑
Heart Surgery	❑	❑	Diabetes	❑	❑	Thyroid Disease	❑	❑	Drug Addiction	❑	❑

Do you have any disease, problem, or condition not listed? ❑ Yes ❑ No **If Yes, What?** _____

Are you currently under the care of a Physician? ❑ Yes ❑ No **If Yes, for What Reason?** _____

Are you now taking any medication, drugs, or pills? ❑ Yes ❑ No **If Yes, please list:** _____

_____

FOR WOMEN ONLY: Are you Pregnant? ❑ Yes ❑ No Are you taking Birth Control Pills? ❑ Yes ❑ No

Nearest Relative not living with you? _____ Relationship _____ Phone _____

ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

Patient (or Guardian) Signature _____ Date _____

MEDICAL HISTORY REVIEW: I have reviewed this medical history and have added any changes since my last review.

Initial _____ Date _____	Initial _____ Date _____	Initial _____ Date _____	Initial _____ Date _____
Dr. Initial _____	Dr. Initial _____	Dr. Initial _____	Dr. Initial _____

DENTAL INFORMATION

What prompted you to seek dental care at this time?

_____

How long since you have been to the dentist? _____

What was done then? _____

Why are you changing dentists? _____

Has the fear of discomfort kept you from regular dental visits?
❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No Why? _____

Have they been replaced by: ❑ Fixed Bridge ❑ Removable Partial
❑ Implant ❑ Denture ❑ Nothing

Are you happy with the replacement? ❑ Yes ❑ No

Are any of your teeth sensitive to: ❑ Heat ❑ Cold ❑ Biting Pressure

Have you had your teeth straightened (braces)? ❑ Yes ❑ No

Do you suffer from halitosis (bad breath)? ❑ Yes ❑ No

Are you completely satisfied with your smile? ❑ Yes ❑ No

Is there anything about the appearance of your smile (teeth) that you would like to change? _____

_____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? ❑ Yes ❑ No

How often do you brush your teeth? _____

How often do you use dental floss? _____

Do your gums bleed when you brush or floss? ❑ Yes ❑ No

Have you ever been told you have periodontal (gum) disease?
❑ Yes ❑ No

Have you ever had periodontal (gum) treatments? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Are you aware of your jaw clicking, popping or making grating-like noises? ❑ Yes ❑ No

Have you ever had TMJ treatments? ❑ Yes ❑ No

CONSENT: The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account.

Patient (or Guardian) Signature _____ Date _____

IF YOU HAVE DENTAL INSURANCE . . . . Please complete the following thoroughly. We can place the information into our computer and bill your insurance carrier automatically. This service is FREE to you. A completed and signed insurance form MUST be provided on each visit unless otherwise informed by this office. As an additional courtesy, our office will accept assignment of benefits if you sign the release below.

PRIMARY INSURANCE

Insured's Name _____ Birthdate _____

Social Sec # _____ Ins. ID # _____

Insurance Company _____

Phone # ( ) _____ Group/Local # _____

Effective Date _____ Relation to Patient _____

Insured's Employer _____

City _____ How long with Company? _____

SECONDARY INSURANCE

Insured's Name _____ Birthdate _____

Social Sec # _____ Ins. ID # _____

Insurance Company _____

Phone # ( ) _____ Group/Local # _____

Effective Date _____ Relation to Patient _____

Insured's Employer _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my Insurance Company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I understand that any amounts paid to this office are ESTIMATES only and I will not know the exact amount owed until my insurance has paid. I further agree that should the amount paid by my insurance be insufficient to cover the entire dental expense, I will be responsible for payment of the difference.

SIGNED _____ Date _____