SANTA MONICA BAY
DENTAL

2730 Wilshire Blvd. Suite 410, Santa Monica, CA 90403 (310) 453-8606
www.smbaydental.com info@smbaydental.com

Name: _____ Date of Birth: _____ ☐ Male ☐ Female
Last First Middle Initial

Address: _____
(mailing) Street City State Zip Code ☐ Single

Address: _____ ☐ Married
(residence) Street City State Zip Code

Telephone (cell): _____ email: _____ Social Security # _____

Telephone (work): _____ ext: _____ Employer: _____

Telephone (home): _____ Preferred Appointment Confirmation Method: email text cell home work

If Child, Parent's or Legal Guardian's Name: _____

Name of Spouse: _____ Birthdate: _____ Social Security # _____

Person Responsible for This Account: _____

In Case of Emergency Who Should We Notify? _____ Telephone: _____

Do You Have Dental Insurance? ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

Is There Secondary Dental Insurance ☐ Yes ☐ No

Name of Insurance Company: _____ Effective Date: _____

Subscriber Name: _____ Social Security # _____ Birthdate: _____

Group or Policy #: _____ Membership #: _____ Dental Plan #: _____

How were you referred to our office? _____

- I grant authority to Santa Monica Bay Dental, its associates, and their practice auxiliaries to perform dental and surgical procedures and treatments, including the administration of medicines and local anesthetics that are deemed necessary and advisable. Patient and/or legal guardian/parent will be informed before treatment is performed.
- I authorize the practice of Santa Monica Bay Dental to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.
- I consent to the taking of photographs and videos before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
- I hereby certify the above to be true and correct to the best of my knowledge.

Authorized Signature: _____ Date: _____

Reviewed by: _____
Date: _____

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MEDICAL HISTORY

Name:_____ Date of Birth _____

Personal Physician _____ Phone_____

Last seen by physician _____ Reason _____

How would you describe your overall health? Good / Fair / Poor

Please answer the following questions to the best of your knowledge:

Y / N Are you under the regular care of a physician?

Y / N Do you currently take **ANY** medications or supplements? Please list:_____

_____

Y / N Have you EVER had any reactions to ANY of the following: (If yes, please check)

☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Aspirin ☐ Tetracycline ☐ Dental Anesthetic

☐ Vicodin ☐ Other _____

Y / N Have you EVER had any major operations or overnight stay in the hospital?

Explain: _____

Y / N Are you aware of any bleeding problems? Explain:_____

Y / N Have you EVER taken any of the following medications for osteoporosis? If yes, please note year began.

_____ Boniva _____ Fosamax _____ Actonel _____ Didronel _____ Skelid

Y / N Do you currently or have you EVER smoked cigarettes:

If yes, how often? _____ Packs/day for _____ Years or Date quit: _____

Y / N Have you ever been instructed to pre-medicate before dental treatment? Explain: _____

To the best of your knowledge, do you have, or have you EVER had, any of the following:

☐ Heart Disease or Heart Problems
☐ Hi Blood Pressure
☐ Low Blood Pressure
☐ Heart Attack or Angina
☐ Heart Murmur or Mitral Valve Prolapse
☐ Stroke
☐ Pacemaker
☐ Blood Thinners
☐ Abnormal Bleeding
☐ Abnormal Healing
☐ Blood Transfusion
☐ Rheumatic Fever
☐ Endocarditis
☐ Anemia or Other Blood Disorders
☐ Shortness of Breath of Chest Pain
☐ Epilepsy or Seizures
☐ Fainting Spells
☐ Dizziness
☐ Diabetes Type____ A1C ____
☐ Tumors or Growths
☐ Cancer
☐ Chemotherapy
☐ Radiation Therapy
☐ Frequent Headaches
☐ Sinus Problems
☐ Asthma or Difficulty Breathing
☐ Emphysema or COPD
☐ Tuberculosis
☐ Hepatitis Type____
☐ Jaundice or Other Liver Disease
☐ Ulcers
☐ Kidney or Bladder Trouble
☐ Frequent Vomiting or Diarrhea
☐ Unexplained Weight Loss or Gain
☐ Unexplained Swelling of Hands, Feet or Eyes
☐ Glaucoma
☐ Arthritis or Rheumatism
☐ Painful or Swollen Joints
☐ Artificial Joints: Year placed _____
☐ Thyroid or Parathyroid Problems
☐ Rashes or Skin Disorders
☐ HIV or AIDS
☐ Neurological Problems
☐ Psychological or Psychiatric Treatment
☐ Drug or Alcohol Abuse
☐ Latex Sensitivity
☐ Cold Sores/Fever Blister

For Women Only:

☐ Pregnant ☐ Nursing ☐ Birth Control Pills

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Date: _____

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DENTAL HISTORY

Name:_____Date of Birth _____

Our Practice is committed to providing each of our patients with individualized private care treatment consistent with their particular needs, wants, and values. By answering the following questions candidly you will help us better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1. What prompted you to contact our office for an appointment? _____
2. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
3. Have you ever had any serious trouble associated with previous dentistry? ☐ Yes ☐ No

   _____

   _____
4. When was your last dental visit? _____ What was done? _____
   Last Full Mouth Set of X-rays? _____
5. Do you use the following?

Toothbrush manual or electric	☐Yes	☐No	How Often? _____
Dental Floss	☐Yes	☐No	How Often?_____
Other Oral Hygiene Device	☐Yes	☐No	What and how often? _____

6. Do you have or ever had any of the following?

☐ Orthodontic Treatment (braces)	☐ Oral Surgery	☐ Periodontal Treatment
☐ Teeth Sensitive to hot, cold, sweet	☐ Clicking/Popping Jaw	☐ Bleeding/Sore Gums
☐ Teeth Sensitive to chewing	☐ Clenching or Grinding	☐ Loose Teeth
☐ Unpleasant taste or bad breath	☐ Difficulty opening or closing	☐ Serious Injury
☐ Bite Plate or Mouth Guard	☐ Shift or change in bite	☐ Snoring/Sleep Apnea

7. On a scale of 1 to 10 (1 being terrible and 10 being perfect)
   1. How healthy do you think your mouth is? _____
   2. How healthy would you like your mouth to be? _____
8. Are you happy with the appearance of your teeth? ☐Yes ☐No
   If you answered 'No' and we could snap our fingers and instantly change anything about the appearance of your teeth what would you change? _____

   _____
9. Do you expect to keep your teeth for the rest of your life? ☐Yes ☐No
10. What do you value most about your teeth? (remember…there are no wrong answers)
    - ☐ How they feel (i.e.: clean, strong, no pain…)
    - ☐ How they work; how you chew
    - ☐ How they look; having a great smile!

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PERIODONTAL HISTORY

Name:_____Date of Birth _____

Please answer the following questions to the best of your knowledge:

Y / N Do you consider yourself to be in good dental health? If no, please explain:_____

_____

Y / N Do you think your teeth are affecting your health in any way? If yes, please explain:_____

_____

Y / N Are you satisfied with the appearance of your smile, teeth and gums? If no, please explain:_____

_____

Y / N Do you have any dental anxiety?

Y / N Do you have difficulty chewing?

Y / N Have you noticed any loosening of your teeth?

Y / N Have you noticed any bleeding, swelling or discomfort of your gums? Please explain:_____

_____

Y / N Are you often bothered by food getting caught between your teeth?

Y / N Have you ever been treated by a periodontist? If so, what year and what treatment received, to the best of your knowledge:_____

_____

Y / N Do you suffer from jaw pain?

Y / N Have you experienced popping or clicking in your jaw?

☐ No ☐ Yes, occasionally, without pain ☐ Yes, accompanied by pain

Y / N Have you experienced dislocation (locking) of the jaw?

☐ No ☐ Yes, it was stuck open ☐ Yes, stuck closed or restricted opening

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ACKNOWLEDGEMENT FORM

Name:_____Date of Birth _____

Patient Acknowledgement of Receipt of Dental Material Fact Sheet

I acknowledge that I have been offered a copy of the Dental Material Fact Sheet dated October 2001.

Patient Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

Patient Signature _____ Date _____

For Office Use Only
We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices, but it was not obtained because:

- ____ Individual Refused to Sign
- ____ Communication barriers prohibited obtaining the acknowledgement.
- ____ An emergency situation prevented us from obtaining the acknowledgement.
- ____ Other _____

Financial Policy

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that payment is due at the time of service unless other arrangements have been made.

In the event that payment is not received within ninety (90) days from date of service a late charge of 1.5% of the balance with be added to my account per month (18% APR), unless other arrangements have been made.

Payments are accepted in: Cash, Checks, Visa, MasterCard, American Express
Care Credit is available for balances over $1500 (must qualify)

Patient Signature _____ Date _____

Reviewed by: _____
Date: _____