



2730 Wilshire Blvd. Suite 410, Santa Monica, CA 90403 (310) 453-8606

www.smbaydental.com

info@smbaydental.com

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

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

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

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:

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

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

9. Do you expect to keep your teeth for the rest of your life? Yes No

10. What is most important about your teeth? _____

11. Why do you want to keep your teeth for life? _____

12. What are your concerns about getting the dental treatment you may need? _____

Reviewed by: _____

Date: _____



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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 will 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: _____