

WELCOME TO SOUTHBAY DENTISTRY & ORTHODONTICS



Date _____

Home Phone _____

E-mail _____

Cell Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone (_____)

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____)

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone (_____)

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____)

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone (_____)

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____)

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for

services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

DENTAL HEALTH HISTORY (Confidential)



DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment? |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sores or growths in your mouth |

Are you happy with your smile? _____ Would you like to have whiter teeth? _____ Did you wear braces before? _____

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physician care? _____ Please describe _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |

Are you currently taking any medication? _____

UPDATE

UPDATE

ALLERGIES

Date _____

Health Changes _____

Medicine _____

Patient's Signature _____

Date _____

Health Changes _____

Medicine _____

Patient's Signature _____

- Aspirin
- Codeine
- Local Anesthetic
- Penicillin
- Other _____

SIGNATURE

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

I have received a copy of the Dental Material Fact Sheet as required by law.

Authorization must be signed by the patient, or by nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ Date: _____ Relationship to Patient: _____