

# Welcome



**SANTA ANA  
DENTAL GROUP**

*Affordable and comfortable dental care*

715 S. Main Street • Santa Ana, CA 92701

Date \_\_\_\_\_

DL# \_\_\_\_\_

Soc. Security \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

## ***Patient Information*** (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

If Patient is a Student, Name of School / College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone ( ) \_\_\_\_\_

## ***Responsible Party*** (Same as Above) Circle

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Driver's license # \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## ***Referral Information***

Were you referred by one of our Patients?  Yes  No

If Yes, Whom may we thank? \_\_\_\_\_

If No, How did you find us? \_\_\_\_\_

## ***Insurance Information***

Name of the Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Address of Employer \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## ***HIPPA Acknowledgement***

I have read and been offered a copy of the Santa Ana Dental Group Notice of Privacy Practices.

Signed \_\_\_\_\_ Print Name \_\_\_\_\_

Signature of patient or parent (if minor) \_\_\_\_\_ Date \_\_\_\_\_

# Patient Information (CONFIDENTIAL)

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
1. Are you under medical treatment right now?.....	<input type="checkbox"/>	<input type="checkbox"/>	5. Are you allergic to or have you had any reactions to the following?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. Novocaine) .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medication?.....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>
			Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been prescribed antibiotics prior to dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	6. Women only:		
4a. Have you ever taken phen-phen?.....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be?.....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking birth control pills?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have had any of the following?					
	Yes	No		Yes	No
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Coumadin Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
			Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
			Down Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>
			Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>
			Aids or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
			Other.....	<input type="checkbox"/>	<input type="checkbox"/>

## Patient Dental History

	Yes	No		Yes	No
1. Do your gums bleed while you are brushing or flossing?.....	<input type="checkbox"/>	<input type="checkbox"/>	6. Are you hard to get numb?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids / foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you apprehensive of dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any prolonged bleeding following extraction?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you interested in sleep anesthesia?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	8. Would you be interested in whitening your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever experienced any of the following problems in your jaw?			9. Do you like the appearance of your teeth, your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
a) Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	a) If not, explain _____		
b) Clicking or popping?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
c) Pain (joint, ear, side of face)?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
d) Difficulty in chewing?.....	<input type="checkbox"/>	<input type="checkbox"/>	10. When was your last exam & cleaning done? _____		
e) Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>			

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that no other dentist nor Santa Ana Dental is responsible for my dental treatment. I hereby give my consent to have necessary treatment recommendations performed.

Signature of patient or parent (if minor) \_\_\_\_\_

Doctor's Comments _____	Signature _____	Date _____
Doctor's Comments _____	Signature _____	Date _____
Doctor's Comments _____	Signature _____	Date _____