Welcome to our office!

In order to serve you properly, we need the following information.
All information is strictly confidential. ***(Please print clearly)*** Date:____________________

GENERAL

Patient's Name:____ Sex (M/F) ______ Birth date: ____________________
(First) (Last)

Address: ____ City: ___________________ State: ______ Zip: __________

Home Phone No.: (___) ______________ Work Phone No.: (___) _______________ Cell No. (____) _________________

Driving License No. ____________________ Soc. Sec. No.: _____________________ Referred By: __________________

Email: ____ Occupation: ________________ Marital Status: _______

Person Responsible for the Account – Name: ____
(First) (Last)

Relationship to Patient: __________________ Birth Date: ___________________ Soc. Sec. No.: _____________________

Address: ____ City: ___________________ State:______ Zip:__________

Home Phone No.: (____) ______________ Work Phone No.: (____)_______________ Pager No.: (____) _______________

DENTAL HISTORY

Chief Complaint / Reason for Visit:____

When Was Your Last Dental Visit?_________________ Last Full Mouth X-Ray? _______________ Last Teeth cleaning?_________________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? – (PLEASE CHECK ALL THAT APPLY)

- ☐ Teeth Sensitive to Cold, Heat, Sweet and Pressure
- ☐ Teeth Grinding or Clenching
- ☐ Broken or Chipped Tooth
- ☐ Bleeding Gums? How Long? ____________
- ☐ Pain Around Ear, Neck & Shoulder
- ☐ Finger Nail Biting, Cheek Biting
- ☐ Food Impaction
- ☐ Unusual Sounds in Ear While Eating
- ☐ Frequency of Brushing _________
- ☐ Bad Breath
- ☐ Orthodontic Treatment
- ☐ Dental Floss
- ☐ Mouth Breathing
- ☐ Periodontal Treatment
- ☐ Water Jet Device
- ☐ Cigarettes, Pipe or Cigar Smoking
- ☐ Partial or Complete Denture
- ☐ Professional Teeth Whitening

Are You Satisfied With Your Teeth's Appearance? ____

Please Add Anything You Feel Is Important: ____

INSURANCE

Do You Have Insurance or Dental Plan? ☐Yes ☐ No Insurance Company Name: __________________________ Plan: _______________

Name of Insured: ________________________ Relationship to Patient:________________________ Soc. Sec. No. _____________________

Do You Have Any Other Dental Insurance? ☐ Yes ☐ No If Yes, Insurance Company Name:_____________________ Plan:___________

I authorize the release of any medical/dental/personal information necessary to process dental claim, and I authorize payment of dental benefit to the Dental Group of Beverly Hills for professional services rendered.

Signature: ________________________________

I authorize the dental staff to perform any necessary dental service(s) with my informed consent that I may need during diagnosis and treatment. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. It is customary to pay for services when rendered, unless other arrangements have been made in advance. If account is not paid within 90 days of the date of service I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.
I acknowledge that I have received a copy of the "Dental Material Fact Sheet as required by law.
I acknowledge that I have received a copy of the "Notice of Privacy Practices".

Signature: _______________________________

Thank you for choosing our office!