

# Silver Lake Dental Arts

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&

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## PERSONAL INFORMATION

FIRST NAME

MIDDLE

LAST

MALE or FEMALE

DAY TIME PHONE

CELL PHONE

NIGHT TIME PHONE

HOME ADDRESS

STREET

CITY

ZIP

SOCIAL SECURITY NUMBER

BIRTHDATE

SPOUSE/PARENT

SPOUSE/PARENT SOCIAL SECURITY No.

PHONE No.

WHO DO WE CONTACT IN CASE OF EMERGENCY? (NAME/RELATION/CONTACT No.)

FAMILY MEMBERS WHO ARE ALSO PATIENTS?

WHO MAY WE THANK FOR REFERRING?

## DENTAL INSURANCE

SUBSCRIBER

BIRTHDATE

SOCIAL SECURITY No.

EMPLOYER

INSURANCE COMPANY NAME

PROGRAM/POLICY No.

UNION LOCAL No.

INSURANCE COMPANY ADDRESS

SECONDARY INSURANCE?

SUBSCRIBER

BIRTHDATE

SOCIAL SECURITY No.

PROGRAM/POLICY No.

INSURANCE COMPANY NAME

## ASSIGNMENT & RELEASE

I CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AS INDICATED AND DISCLOSED ACCURATELY TO SILVERLAKE DENTAL ARTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. THEREFORE INCLUDING IF I DO NOT HAVE INSURANCE COVERAGE.

I AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE

DATE

RELATIONSHIP TO MINOR (IF APPLICABLE)

## DENTAL HISTORY

REASON FOR TODAY VISIT? \_\_\_\_\_

FORMER DENTIST PHONE No. \_\_\_\_\_

DATE OF LAST DENTAL VISIT \_\_\_\_\_

DATE OF LAST DENTAL X-RAYS \_\_\_\_\_

HOW OFTEN DO YOU:

FLOSS? \_\_\_\_\_

BRUSH? \_\_\_\_\_

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT?

YES/NO

ARE YOU CURRENTLY IN PAIN?

YES / NO

HAVE YOU EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?

YES / NO

DO YOU LIKE YOUR SMILE?

YES / NO

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?

YES / NO

HAVE YOU EVER EXPERIENCED UNFAVORABLE DENTAL TREATMENT?

YES / NO

DO YOU WISH TO USE NITROUS OXIDE WITH YOUR DENTAL TREATMENT?

YES / NO

BAD BREATH Y / N

BLEEDING GUMS Y / N

BLISTERS LIP OR MOUTH Y / N

CHEWING ON SINGLE SIDE Y / N

DRY MOUTH Y / N

FOOD COLLECTING Y / N

GRINDING TEETH Y / N

GUMS SWOLLEN Y / N

GUMS TENDER Y / N

JAW PAIN Y / N

JAW TIREDNESS Y / N

MOUTH BREATHING Y / N

PAIN AROUND EAR Y / N

SENSITIVITY TO COLD Y / N

SENSITIVITY TO HOT Y / N

IS THERE ANYTHING ELSE ABOUT YOUR DENTAL CARE YOU WOULD LIKE US TO KNOW?

\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

YOUR CURRENT PHYSICAL CONDITION IS?

GOOD / FAIR / POOR

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?

YES / NO

EXPLAIN \_\_\_\_\_  
PHYSICIAN NAME \_\_\_\_\_  
NUMBER \_\_\_\_\_

ARE YOU TAKING ANY PRESCRIPTION/ OVER THE COUNTER DRUGS?

YES / NO

PLEASE LIST:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE OR USE TOBACCO IN ANY FORM?

YES / NO

FOR WOMEN:

ARE YOU TAKING BIRTH CONTROL?

YES / NO

ARE YOU PREGNANT? OR TRYING?

YES / NO

ARE YOU NURSING?

YES / NO

LIST ALLERGIES, MEDICATIONS, LATEX, GLUTEN?

\_\_\_\_\_  
\_\_\_\_\_

PLEASE CIRCLE ANY OF THE FOLLOWING IF THEY PERTAIN TO YOU:

|                      |                     |
|----------------------|---------------------|
| ABNORMAL BLEEDING    | HERPES              |
| ALCOHOL/DRUG ABUSE   | HIGH BLOOD PRESSURE |
| ALZHEIMER'S          | HIV+/ AIDS          |
| ANEMIA               | JOINT REPLACEMENT   |
| ARTHRITIS            | KIDNEY PROBLEMS     |
| ARTIFICIAL           | LIVER DISEASE       |
| BONES/JOINTS/VALVES  | LOW BLOOD PRESSURE  |
| ASTHMA               | MITRAL VALVE        |
| BLOOD TRANSFUSION    | PROLAPSE            |
| BRUISE EASILY        | NERVOUS/ANXIOUS     |
| CANCER/CHEMOTHERAPY  | PACEMAKER           |
| COLITIS              | PSYCHIATRIC CARE    |
| DIABETES             | PSYCHOLOGICAL CARE  |
| DIFFICULTY BREATHING | RADIATION TREATMENT |
| EMPHYSEMA            | RHEUMATIC FEVER     |
| EPILEPSY             | SEIZURES            |
| FADING SPELLS        | SINUS PROBLEMS      |
| FEVER BLISTERS       | STROKE              |
| FREQUENT HEADACHES   | THYROID PROBLEMS    |
| GLAUCOMA             | TUBERCULOSIS (TB)   |
| HAY FEVER            | TUMORS OR GROWTHS   |
| HEART PROBLEMS       | ULCERS              |
| HEART MURMUR         | VENEREAL DISEASE    |
| HEMOPHILIA           |                     |
| HEPATITIS            |                     |

BY SIGNING HERE, I AM CERTIFYING THAT TO THE BEST OF MY KNOWLEDGE, THE ANSWERS ABOVE ARE TRUTHFUL.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE