

MANHATTAN BEACH DENTAL CENTER

1151 N. Sepulveda Blvd.
Manhattan Beach, CA 90266

Patients Name _____ (Last) (First) (Middle Initial) (Nickname) _____ Date: _____

Address _____

City _____ State _____ Zip _____

Drivers License # _____ Male Female Single Married Child Other _____

Home Phone # _____ Work Phone # _____ Mobile# _____

Email address _____

Best form of communication: I prefer email text phone call Do you give our office permission to contact you? _____

Employer _____ Occupation _____

Employer Address _____

In Case of Emergency Contact:

Name _____ Relationship _____

Address _____ Contact # _____

Who may we thank for referring you? _____

Account Information:

Individual Responsible for this account _____ (Last) (First)

Relationship to patient _____ DOB: _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Group # _____

Insurance Carrier _____ Customer Service # _____

Claims Mailing Address _____

City _____ State _____ Zip _____

Any additional insurance coverage:

Relationship to patient _____ DOB: _____ Social Security # _____

Employer _____ Group # _____

Insurance Carrier _____ Customer Service # _____

Claims Mailing Address _____

City _____ State _____ Zip _____

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorizes DHA to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by DHA to make a thorough diagnosis of patient's dental needs. I also authorize DHA to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that doctor DHA choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

Patient/Guardian Signature

Date

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HEALTH HISTORY

Patient Name _____ DOB: _____
Physicians' Name _____ Phone # _____
Physicians Address _____ City _____ Zip _____

MEDICAL

- 1. Are you in good health? _____ YES NO
- 2. Has there been any change in your general health within the past year? _____ YES NO
- 3. Date of last physical examination? _____
- 4. Are you now under the care of a physician? _____ YES NO
If so what condition? _____
- 5. Have you ever had any serious illness, operation, or hospitalization? _____ YES NO
- 6. Are you taking any drugs or medication? _____ YES NO
- 7. List type amount and frequency if so _____
- 8. Are you using any recreational drugs? _____ YES NO
- 9. Are you taking any over the counter drugs? _____ YES NO
- 10. Are you sensitive or allergic to any medication? _____ YES NO

Penicillin Sulfa Codeine/other Narcotic Aspirin Barbiturates Iodine other _____

- 11. Do you have or have you had any of the following: (Please check known conditions)
- | | | | |
|---------------------|---------------------------|--------------------------------------|---------------------|
| Aids or HIV | Rheumatic Fever | Arthritis | Diabetes |
| Anemia | Blood Diseases _____ | Head Injuries | Epilepsy |
| Artificial Joints | Sinus Trouble | Stomach Ulcers | Stroke |
| Heart Ailments | Sickle Cell Anemia | Venereal Disease | Heart Murmur |
| High Blood Pressure | Kidney Disease | Mental Disorders | Respiratory Disease |
| Tumors/Growths | Tuberculosis | Radiation treatment | Asthma/Hay Fever |
| Nervous Disorders | Allergies _____ | Glaucoma | None of the above |
| Excessive Bleeding | Fainting Spells/ Seizures | Hepatitis, Jaundice or liver disease | |
| | | Other _____ | |

If you checked yes to any of the above conditions, please give a brief explanation:

- 12. Do you use tobacco now or in the past? _____ YES NO
- 13. Do you wear a cardiac pacemaker? _____ YES NO
- 14. Have you had Heart surgery? _____ YES NO
- 15. Do you have any disease or condition or problem not list above that you think I should know about? _____ YES NO
If yes, what is it? _____
- 16. If you are Women, are you pregnant or nursing? If so, how many months? _____

DENTAL

- 1. Previous Dentist _____ City _____ State _____ Zip _____
 - 2. Was your pattern of visits regular infrequent sporadic Date of Last Dental Visit _____
 - 3. Have you been having any specific problems? _____ YES NO
Explain _____
 - 4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment? _____ YES NO
 - 5. Does dental treatment make you nervous? _____ YES NO
 - 6. Do you have or have not had any of the following: (Please check known conditions)
- | | | |
|-------------------------------|--------------------|---------------|
| Bad Breath | Loosening of teeth | Bleeding gums |
| Cold sores | Clench your teeth | |
| Sensitive Teeth at | Night Day Sweet | Temperature |
| Grind your teeth at | Night Day Hurt | Lock Jaw Pop |
- 7. Have you ever had any serious trouble associated with any previous dental treatment? _____ YES NO
 - 8. Have you ever had any of the following: _____ YES NO
Injury Oral Surgery Orthodontics Periodontics
 - 9. Is there anything about the appearance of your teeth you have ever wanted to change?
Explain _____

Patient/Guardian Signature Date Doctor Signature