MANHATTAN BEACH DENTAL CENTER

1151 N. Sepulveda Blvd.
Manhattan Beach, CA 90266

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

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:
   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