



PATIENT INFORMATION

Name _____ M / F Birth date _____

Age _____ SS# _____ Driver's License# _____

Home Address _____

City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Referral source _____ Reason for this visit _____

E-mail address _____ Date of last dental visit _____

Employer _____ Occupation _____

Business address _____ Business phone _____

Full-Time student: Y / N If yes, College name/city _____

INSURANCE POLICY

Do you have insurance? Y / N Insurance name _____

Policy holder name _____ Policy holder D.O.B _____

Policy holder SS# _____ Policy holder D.L.# _____ Phone _____

HEALTH HISTORY

Physician _____ Phone _____

In case of emergency, contact _____ Phone _____

Are you currently taking prescribed medications? Y / N If yes, what? _____

Are you sensitive to any drugs? Y / N If yes, what? _____

Women: Are you pregnant? Y / N

Have you ever had:

- | | | | |
|-------------------|-----------------------|---------------------|--------------------|
| Abnormal bleeding | Tuberculosis | Rheumatic fever | Cancer |
| Hepatitis | Heart disease | High blood pressure | Kidney disease |
| HIV | Pacemaker | Asthma | Fainting incidents |
| Herpes | Mitral valve prolapse | Diabetes | Smoke/Tobacco use |
| Artificial joints | Heart murmur | Epilepsy | Osteoporosis |

Do you have or have had any medical conditions that are not listed above? _____

Have you ever had:

- history of pain or locking in your jaw? problems due to clenching or grinding your teeth?
- painful or swollen gums? bleeding gums when brushing your teeth?
- tooth sensitivity due to: cold, heat, sweets, chewing pressure?

Are there any other oral symptoms you would like to discuss? _____

CONSENT

This is to certify that I consent to the performing of whatever dental procedures may be decided upon to be necessary or advisable by Studio City Dental Group. I hereby authorize Studio City Dental Group to release any and all dental and medical information to insurance carrier(s) for the purpose of claims evaluation and processing. I hereby authorize my insurance carrier(s) to pay directly to Studio City Dental Group the benefits otherwise payable to me. I hereby authorize Studio City Dental Group to obtain my credit history. I understand I am financially responsible for all charges. I authorize Studio City Dental Group to use my photographs, x-rays, and other dental records for educational purposes. These authorizations remain valid until revoked in writing. I understand that each patient is unique and that dental treatment cannot be guaranteed. I have answered every question completely and accurately. I will inform Studio City Dental Group of any changes in my health, medications, or relevant personal information.

Signature (responsible party) _____ Date _____

UPDATE

I have reviewed and updated the medical history and have made any necessary changes.

Signature (responsible party) _____ Date _____

Signature (responsible party) _____ Date _____

Signature (responsible party) _____ Date _____

Signature (responsible party) _____ Date _____

Signature (responsible party) _____ Date _____