



**PATIENT INFORMATION**

Name \_\_\_\_\_ Sex: 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 or over the counter medications? Y / N If yes, what? \_\_\_\_\_

Sensitivity 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?       Frequently clenching or grinding your teeth?  
 Gums feel painful or swollen?       Bleeding in your gums when you brush your teeth?  
 Pain in your teeth because of heat, cold, sweets, or chewing?

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 \_\_\_\_\_