NEWPORT BEACH DENTAL ASSOCIATES

I. PATIENT INFORMATION

PLEASE PRINT

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Please Check
MARRIED ❒
SINGLE ❒
DIVORCED ❒
WIDOWED ❒
CHILD ❒

MR / MS / MRS / MISS
LAST NAME FIRST NAME MIDDLE NAME

STREET ADDRESS

CITY ZIP CODE

( ) HOME PHONE ( ) WORK PHONE

( ) CELL PHONE AGE

PATIENT SOCIAL SECURITY #

PLEASE CHECK
MALE ❒
FEMALE ❒

BIRTHDAY MONTH DAY YEAR

OCCUPATION HOW LONG EMPLOYED

EMPLOYER NAME

E-MAIL ADDRESS

RELATIONSHIP TO PATIENT
PARENT ❒ LEGAL GUARDIAN ❒ STEPPARENT ❒ OTHER____________

II. INSURANCE INFORMATION PARENT/RESPONSIBILE PARTY

PLEASE CHECK
MALE ❒
FEMALE ❒

INSURED EMPLOYEE (PRIMARY)

MR / MS / MRS / MISS
LAST NAME FIRST NAME MIDDLE NAME

SOC SEC • INSURED EMPLOYEE
NAME OF EMPLOYER / COMPANY
BIRTHDAY • INSURED EMPLOYEE
EMPLOYEE ADDRESS CITY STATE
INSURANCE CO (CARRIER)
INSURANCE PHONE #
INSURANCE I.D. #
PLAN GROUP NUMBER

III. DUAL INSURANCE INFORMATION

(Complete only if you or your spouse have additional insurance coverage.)

PLEASE CHECK
MALE ❒
FEMALE ❒

INSURED EMPLOYEE (SECONDARY)

MR / MS / MRS / MISS
LAST NAME FIRST NAME MIDDLE NAME

SOC SEC • INSURED EMPLOYEE
NAME OF EMPLOYER / COMPANY
BIRTHDAY • INSURED EMPLOYEE
EMPLOYEE ADDRESS CITY STATE
INSURANCE CO (CARRIER)
INSURANCE PHONE #
INSURANCE I.D. #
PLAN GROUP NUMBER

IV. GENERAL HEALTH INFORMATION

1. Are you under a doctors care at this time? YES NO If yes, please specify ____________

Physician's name and number ____________

2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? ____________

3. Are you taking any medication at this time? YES NO If yes, please specify ____________

4. (Women) Are you pregnant at this time? YES NO If yes, please specify how many months ____________

5. Do you take or have you ever taken Bisphosphonates. Specify date: _______ YES NO

6. Please check all of the following either YES NO

AIDS	YES ❑	NO ❑	COLD SORES	YES ❑	NO ❑	HEART ATTACK	YES ❑	NO ❑	LIVER PROBLEMS	YES ❑	NO ❑
ALLERGIES	YES ❑	NO ❑	DIABETES	YES ❑	NO ❑	HEART BYPASS	YES ❑	NO ❑	LOW BL PRESSURE	YES ❑	NO ❑
ANEMIA	YES ❑	NO ❑	DIZZY SPELLS	YES ❑	NO ❑	HEART MURMUR	YES ❑	NO ❑	LUNG DISEASE	YES ❑	NO ❑
ANGINA	YES ❑	NO ❑	EMPHYSEMA	YES ❑	NO ❑	HEART PROBLEMS	YES ❑	NO ❑	RHEUMATIC FEVER	YES ❑	NO ❑
ARTHRITIS	YES ❑	NO ❑	EPILEPSY	YES ❑	NO ❑	HEPATITIS	YES ❑	NO ❑	SINUS TROUBLE	YES ❑	NO ❑
ARTIFICIAL PROSTHESES	YES ❑	NO ❑	FAINTING	YES ❑	NO ❑	HIGH BL PRESSURE	YES ❑	NO ❑	STROKE	YES ❑	NO ❑
ASTHMA	YES ❑	NO ❑	FEVER BLISTERS	YES ❑	NO ❑	JAUNDICE	YES ❑	NO ❑	THYROID PROBLEMS	YES ❑	NO ❑
CANCER	YES ❑	NO ❑	GLAUCOMA	YES ❑	NO ❑	KIDNEY DISEASE	YES ❑	NO ❑	TUBERCULOSIS	YES ❑	NO ❑
ALLERGIC TO LATEX	YES ❑	NO ❑	HIV	YES ❑	NO ❑	HAVE YOU EVER TAKEN PHEN FEN	YES ❑	NO ❑	VENEREAL DISEASE	YES ❑	NO ❑

V. DENTAL INFORMATION

1. Why are you here today? Check-up ❑ Cleaning ❑ Toothache ❑ Other ____________

2. When did you last visit a dentist? ____________ 3. What treatment was performed? ____________

4. Was the treatment completed ____________ 5. Did you have a cleaning? ____________ 6. When were dental X- rays last taken? ____________

7. Have you ever had prolonged bleeding? YES NO

8. Have you had any problems with past dental treatment? YES NO If yes, please specify ____________

9. Do your gums bleed easily? YES NO 10. Do you feel you have bad breath? YES NO 11. Are your teeth sensitive to hot or cold? YES NO

I have filled out this questionnaire completely and I have advised you of all medical problems of which I am aware

____________ ____________
Date **Signature**

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy

____________ ____________
Date **Signature**

My dental treatment and possible alternatives have been discussed with me. I have been informed of all risks involved with my dental care and anesthesia, including possible blood loss and infection. I hereby consent to the administration of anesthesia and the dental treatments specified by the diagnosing doctor.

____________ ____________
Date **Signature**