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Thank you for choosing us as your dental provider. To provide you with dental services, we require the following information. Please print legibly. Please complete all information in-full so we may better serve you.

1) Please enter today's date: / /
month / day / year

All information kept Confidential.

Your Patient Information:

2) Name: _____
last first middle initial

3) Home address: _____
street Apt.#

_____ city state zip

4) Home telephone #: () _____

5) Birth-date: / / 6) Age: 7) Sex: M / F
month / day / year

To help verify your insurance coverage, we require the following:

8) Social Security #: - - 9) Driver's license #: -

10) Patient's employer: _____

11) Work address: _____
street Apt.#

_____ city state zip

12) Work Telephone #: () _____

13) Dental Insurance at Patient's employer:

14) Insurance Plan #: 14a) Group #: (if applicable)

Your Spouse's Information:

15) Spouse's name: _____
last first middle initial

16) Home address: _____
street Apt.#

_____ city state zip

17) Home telephone #: () _____

18) Birth-date: / / 19) Age: 20) Sex: M / F
month / day / year

To help verify your insurance coverage, we require the following:

21) Social Security #: - - 22) Driver's license #: -

23) Spouse's employer: _____

24) Work address: _____
street Apt.#

_____ city state zip

25) Work Telephone #: () _____

26) Dental Insurance at Spouse's employer:

27) Insurance Plan #: 27a) Group #: (if applicable)

28) What would you change about your smile if you could? _____

29) Can we contact you by e-mail: YES NO E-mail Address? _____

30) Has any member of your immediate family been seen by us in our Lakewood or Cerritos offices? _____

Who? _____ When? _____

31) When was your last visit to a dentist? _____

Who? _____ Reason? _____

32) Who referred you to our office? _____

33) What is your reason for visiting us today? _____

FOR OFFICE USE ONLY	Patient's Ins. Effective date: _____ Guaranteed Eligibility Signed: _____	Spouse's Ins. Effective date: _____ Guaranteed Eligibility Signed: _____
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MEDICAL HISTORY

Please complete the following Medical History questions. All information is kept Confidential.

34) Are you allergic to anything? YES NO What? _____

35) What is the name of your Physician? _____ City: _____ Phone #: _____

36) Are you currently in good health? YES NO Please explain: _____

37) Do you take any medications? YES NO Which? _____

38) Are you allergic to any medications? YES NO Which? _____

39) When was the last time you visited a doctor? _____

40) Whom can we contact in case of Emergency? _____ Relation: _____ Phone #: _____

41) Do you have or have you ever had the following: (**Circle YES or NO for each listed**)

- | | | |
|--|-------------------------------------|---|
| YES NO Arthritis or Rheumatism | YES NO Hepatitis | YES NO Thyroid problems |
| YES NO Rheumatic Fever | YES NO Hemophiliac | YES NO Headaches |
| YES NO Rheumatic Heart Disease | YES NO Fainting spells | YES NO Temporal Mandibular Disorder (TMD/TMJ) |
| YES NO Heart Defect or Murmur | YES NO Seizures | YES NO Drug or Alcohol addiction |
| YES NO Angina or Heart Attack | YES NO Anemia | YES NO Sexually transmitted disease |
| YES NO Pacemaker | YES NO Asthma | YES NO HIV or AIDS |
| YES NO Prosthetic Cardiac Valves | YES NO Glaucoma | YES NO Cancer or Tumor |
| YES NO Complex Cyanotic congenital heart disease | YES NO Stroke | YES NO Radiation treatment |
| YES NO Heart Surgery | YES NO Diabetes | YES NO Chemotherapy treatment |
| YES NO High Blood Pressure | YES NO Epilepsy | YES NO taken "Phen-Fen" |
| YES NO Pulmonary Shunts or conduits | YES NO Tuberculosis | YES NO taken Redux |
| YES NO Mitral Valve Prolapse | YES NO Sinus trouble | YES NO taken Cortisone |
| YES NO Leukemia | YES NO Joint replacement or Implant | YES NO Latex Allergy |
| YES NO Smoke | YES NO Kidney problems | |

42) Do you have any other medical conditions we should be aware of? YES NO Explain: _____

43) For Women: A) Are you pregnant? YES NO B) Are you nursing? YES NO
C) Months pregnant: _____ D) Are you taking birth-control pills? YES NO

44) **This is to certify that I have read and understand the above information. I have completed the requested information and have verified that it is correct and truthful. I have disclosed all information regarding my insurance. I understand that if I am not covered or am ineligible for insurance coverage, I will be responsible for the outstanding portion of fees. I consent to use of the above information for office purposes. I understand that I am responsible for notifying Lakewood Cerritos Dental Centers if there are any changes to the above information. All information given to Lakewood Cerritos Dental Centers is strictly private and will not be released to anyone without written authorization by you.**

43) Patient's Signature: X 44) Date: / /

FOR OFFICE USE ONLY	I have reviewed this patient's information and medical history above.	FOR OFFICE USE ONLY
Doctor's Signature: _____	Date: <u> / /</u>	