Prestige Dental
Family, Cosmetic and Implant Dentistry

Tel: 626.577.2017
Fax: 626.577.2003
1060 E. Green St., Suite 203
Pasadena, CA 91106
frontdesk@prestige-dental.net

Patient Information Form

Today's Date_____

Patient Name: First_____ MI_____ Last_____ Nickname_____

Address: Street_____ Apt/Unit/Suite_____

City_____ State_____ Zip_____

Phone: Mobile_____ Home_____ Work_____

E-Mail_____ **Drivers License #**_____ **State**_____

What is your preferred method of contact? □ Mobile Phone □ Home Phone □ Work Phone □ E-mail

Social Security No._____ - ____ - _____ **Date of Birth**_____/_____/_____

Patient Employed By_____ **Occupation**_____

Work Address: Street_____ City_____ State_____ Zip_____

Sex □ Male □ Female **Marital Status** □ Married □ Single □ Divorced □ Separated □ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient_____ **Mobile Phone**_____ **Home Phone**_____

FOR CHILDREN/MINORS ONLY:

Is the patient a Minor? □ Yes □ No **Full-time Student** □ Yes □ No **Name of School**_____

Name of Responsible Party: First_____ Last_____

Date of Birth_____ **Relationship to Patient** □ Self □Spouse □ Parent □ Other_____

If patient is a Minor, primary residence □Both Parents □Mom □Dad □Step Parent □Shared Custody □Guardian

Address: *(if different from patient)* Street_____ City_____ State___ Zip_____

Phone: Mobile_____ Home_____ Work_____

Employer *(if different from above)*_____**Occupation**_____

Address: Street_____ City_____ State____ Zip_____

Dental Benefit Plan Information

Primary Dental Plan

Name of Insured_____**Birthdate**_____**SSN**_____-____-_____

Insurance Company_____ **Phone**_____

Address: Street_____ City_____ State____ Zip_____

Dental Plan Name_____ **Plan/Group Number**_____

ID Number _____ **Patient Relationship to Insured**_____

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Secondary Dental Plan

Name of Insured_____**Birthdate**_____**SSN**_____-____-_____

Insurance Company_____ **Phone**_____

Address: Street_____ City_____ State____ Zip_____

Dental Plan Name_____ **Plan/Group Number**_____

ID Number _____ **Patient Relationship to Insured**_____

- **Patient Responsibilities:** We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

- **Payment: Payment is due at the time services are rendered**. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash (US currency only), certified check or money order, credit card (Visa, Mastercard, Amex, Discover). Personal checks are also accepted from patients who have established a positive payment history with the practice. Non-sufficient funds or returned checks may be grounds for declining future personal checks and an alternative form of payment may be requested, upon the discretion of the doctor.

- **Dental Benefit Plans:** Your dental insurance benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

  Our practice ❑**IS** ❑**IS <u>NOT</u> (check one)** a contracted provider with your dental benefit plan.

  If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

  If we are <u>not</u> a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment in full to our practice before or at the time of service.

- **Scheduling of Appointments:** We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 24 hour advance notice to reschedule an appointment. **With less than 24 hour notice, a cancellation fee of minimum $50 may be charged or deposit to reserve the appointment time again, may be required.** To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is ten minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of minimum $50 may be charged or deposit to reserve the appointment time again, may be required.

- **Authorizations:** I understand that the information I have provided is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment._____**(initial)**

I have read the above and agree to the financial and scheduling terms._____**(initial)**

I authorize the release of my personal information necessary to process my dental benefit claims, including health information, diagnosis, and records of any treatment or exam rendered. I hereby authorize payment of benefits directly to this dental office otherwise payable to me. ❑ **YES** ❑ **NO** (Check One) _____**(initial)**

Signature_____ Date_____

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Confidential Health History Form

Today's Date_____ **Patient name:** _____ **Birthdate**_____

Primary care physician's name_____ Tel_____

Your pharmacy's name_____ Tel_____

- **Do you have any of the following diseases or problems?**

□ yes □ no Active tuberculosis
□ yes □ no Persistent cough greater than 3 week duration
□ yes □ no Cough that produces blood
□ yes □ no Been exposed to anyone with active tuberculosis

***** IMPORTANT: If you answer <u>YES</u> to any of the four questions above, please stop and return this form to the receptionist.*****

- **Do you have any allergies?** □ yes □ no (If yes, check all that apply)

□ Latex (rubber) □ Foods □ Penicillin □ Codeine or other narcotics
□ Iodine □ Hay fever/seasonal □ Sulfa drugs □ Other (specify)_____
□ Nickel or other metals □ Dental anesthetics □ Aspirin _____

- **Do you have a family history of any of the following?** (Check all that apply)

□ Diabetes □ Heart disease/problems □ Cancer or tumor (specify) _____
□ Bleeding disorders □ High cholesterol □ Other (specify)_____

- **Please list all medications you are currently taking or have taken within the last 3 months.** (Include all over-the-counter medicines, vitamins, and supplements)

_____
_____
_____

- **Please answer the following questions:**

1) Please describe your **general health**: □ good □ fair □ poor
2) Date of last physical exam_____ Results normal?_____
□ yes □ no 3) Has there been any **change in your general health** in the past year?
□ yes □ no 4) Have you had **unexplained weight loss or gain** in the past 6 months?
□ yes □ no 5) Are you currently under the care of a physician?
□ yes □ no 6) Do you have any **organ transplants**? If yes, please describe _____
□ yes □ no 7) Do you have any **artificial joints** (hip, knee replacements, etc.), or are you scheduled for orthopedic joint surgery? If so, have you had complications? _____
□ yes □ no 8) Are you taking, ever been treated with, or scheduled to begin taking oral or intravenous **bisphosphonates** (**Fosamax®, Boniva®**, **Actonel®, Aredia® , or Zometia®**) for osteoporosis, bone pain, Padget's disease, hypercalcemia, myeloma, or cancer? Date treatment began?_____
□ yes □ no 10) Have you ever taken Fen-Phen or other **medications for weight loss**?
□ yes □ no 11) Have you ever had **cosmetic surgery**? If yes, please describe _____
□ yes □ no 12) Do you use **recreational drugs** or controlled substances?
□ yes □ no 13) Do you use **tobacco** (smoking, snuff, chew, bidis)?
If so, _____ per day? How many years _____?
□ yes □ no 14) Do you drink **alcoholic beverages**? If yes, how much usually per week? _____
□ yes □ no 15) Have you **ever been hospitalized or visited the emergency room** for any reason? If yes, please describe reason and list date_____
_____
□ yes □ no 16) Have you had a recent **fever or night sweats**?

Today's Date_____ **Patient name:** _____ **Birthdate**_____

- **Do you currently or have you ever had any of the following conditions?**

CARDIOVASCULAR

□ yes □ no Chest pain (Angina)
□ yes □ no Swollen ankles or feet
□ yes □ no Shortness of breath
□ yes □ no Hardening of arteries
□ yes □ no Heart disease or circulation problems
□ yes □ no Congestive heart failure
□ yes □ no Heart attack
□ yes □ no Heart surgery
□ yes □ no Heart valve replaced
□ yes □ no Heart murmur
□ yes □ no Prolapsed or damaged heart valve
□ yes □ no Pacemaker or defibrillator
□ yes □ no High or low blood pressure
□ yes □ no Heart infection (endocarditis)
□ yes □ no Irregular heartbeat (arrythmia)
□ yes □ no Congenital heart disease
□ yes □ no Rheumatic heart disease or fever
□ yes □ no Scarlet fever
□ yes □ no Stroke

HEAD AND NECK

□ yes □ no Headaches (migraine, tension)
□ yes □ no Snoring or sleep apnea
□ yes □ no Glaucoma or eye disease
□ yes □ no Earaches or hearing problems
□ yes □ no Hearing aid
□ yes □ no Sinusitis, sinus problems
□ yes □ no Difficulty swallowing
□ yes □ no Swollen neck glands
□ yes □ no Recent sore throat or hoarseness
□ yes □ no Neck ache
□ yes □ no Injury to face, head, or neck
□ yes □ no Jaw pain

HEMA/ENDO/IMMUNE

□ yes □ no Bruise easily
□ yes □ no Bleeding problem
□ yes □ no Blood in urine or stool
□ yes □ no Blood transfusion. List date_____
□ yes □ no Anemia
□ yes □ no Denied permission to give blood
□ yes □ no Cancer or tumor
□ yes □ no Radiation treatment or chemotherapy
□ yes □ no Diabetes
□ yes □ no Thyroid or adrenal gland disease
□ yes □ no Rheumatoid arthritis
□ yes □ no Arthritis
□ yes □ no Osteoporosis
□ yes □ no Skin disease or rash
□ yes □ no Cortisone medicine
□ yes □ no Autoimmune disease such as lupus, lichen planus, pemphigus, or Sjogren's
□ yes □ no Blood disease such as lymphoma, myeloma, leukemia

RESPIRATORY

□ yes □ no Asthma
□ yes □ no Bronchitis or emphysema
□ yes □ no Tuberculosis

GASTROINTESTINAL/GENITOURINARY

□ yes □ no Eating disorder or malnutrition
□ yes □ no Frequent vomiting
□ yes □ no Heartburn
□ yes □ no Ulcers or colitis
□ yes □ no Diarrhea
□ yes □ no Constipation
□ yes □ no Blood in stool
□ yes □ no Jaundice (yellow skin or eyes)
□ yes □ no Hepatitis A B C other (**please circle**)
□ yes □ no Liver disease
□ yes □ no Excessive thirst
□ yes □ no Frequent urination
□ yes □ no Bladder infection
□ yes □ no Trouble urinating or blood in urine
□ yes □ no Kidney stones
□ yes □ no Kidney or bladder disease
□ yes □ no Dialysis
□ yes □ no Herpes
□ yes □ no HIV/AIDS
□ yes □ no Sexually transmitted disease

NEUROMUSCULAR/NEUROLOGIC

□ yes □ no Fainting
□ yes □ no Seizures (epilepsy)
□ yes □ no Numbness or paralysis
□ yes □ no Muscle weakness or multiple sclerosis
□ yes □ no Bell's Palsy
□ yes □ no Backaches
□ yes □ no Dizziness or vertigo
□ yes □ no Blurred vision
□ yes □ no Stiffness or painful joints
□ yes □ no Neurological problems
Specify_____
□ yes □ no Mental health disorder
Specify_____
□ yes □ no Psychiatric or emotional counseling
□ yes □ no Depression
□ yes □ no Anxiety
□ yes □ no Drug use or drug addiction
□ yes □ no Alcohol abuse or addiction

WOMEN ONLY

□ yes □ no Currently or could be pregnant
If yes, no. of wks_____
□ yes □ no Currently nursing
□ yes □ no Taking birth control pills
□ yes □ no Taking hormones
□ yes □ no Do you menstruate regularly?

Today's Date_____ **Patient name:** _____ **Birthdate**_____

- **Do you currently or have you ever had any diseases, problems, surgeries or conditions not listed on the previous pages? □ yes □ no. If yes, please describe**

  _____
  _____
  _____
  _____
  _____

I certify that I have read and understand the above information. I acknowledge that I have answered every question on this form truthfully and accurately to the best of my ability. I understand the importance of a truthful health history, and that my dentist and his staff will rely on this information for treating me. If ever my health or medications change, I will promptly inform my dentist. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. The practice of dentistry involves treating the whole person. If my dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize my dentist to contact my physician. I will not hold my dentist or any member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's signature: _____ **Date**_____
(If patient is a minor, parent or legal guardian signature required)

Parent/legal guardian name (for minors only)**:** _____

Office use only: Pulse _____ HR _____/min Resp _____/min

Doctor's Comments: _____
_____
_____
_____
_____
_____

Reviewed By
(Dentist's signature): _____ **Date**_____

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Confidential Dental History Form

Today's Date_____ Patient name: _____ Birthdate_____

- What is the reason for your visit today?_____
- Previous dentist's name_____ Phone_____
- Date of last dental exam and x-rays_____
- Date of last hygiene appointment (cleaning or periodontal maintenance)_____

Please answer the following questions:

□ yes □ no Are you experiencing pain now? If yes, please describe_____
_____
□ yes □ no Have you had problems with prior dental treatment or a bad experience in the dental office? If yes, please describe_____
□ yes □ no Are you anxious about receiving dental treatment?
□ yes □ no Has your physician or previous dentist ever recommended that you take antibiotics prior to dental treatment (antibiotic prophylaxis)? If yes, why?_____
□ yes □ no Have you ever had orthodontic treatment (braces)? If yes, when?_____
□ yes □ no Have you ever had gum tissue (periodontal) treatment including deep cleanings, root planning or gum surgery? If yes, when?_____
□ yes □ no Have you ever had a biopsy in your mouth? If yes, why?_____
□ yes □ no Have you ever whitened your teeth in the past? If yes, what method?_____
□ yes □ no Do you play sports involving contact? If yes, what sports?_____
□ yes □ no Do you currently wear or previously have worn a nightgaurd or bite appliance?
□ yes □ no Do you snore or have sleep apnea?
□ yes □ no Have you ever had prolonged bleeding after extractions or dental surgery?
□ yes □ no Do you gag easily (have a strong gag reflex)?
□ yes □ no Do you have limited opening of your mouth?
□ yes □ no Are you able to sit for long dental appointments (2-3 hours)?
□ yes □ no Do you have any backaches, neckaches, vertigo, or shortness of breath that will prevent you from lying flat on your back? If yes, please describe_____

What concerns do you have with your teeth or smile? (Check all that apply)

□ Jaw joint pain or clicking/popping
□ Clenching, grinding, or bruxing
□ Overbite
□ Underbite
□ Uncomfortable bite
□ Bite adjusted previously
□ Need to chew on one side
□ Difficulty or pain when chewing
□ Difficulty swallowing
□ Speech problems
□ Canker/cold sores
□ Swollen neck glands or face
□ Bleeding or swollen gums
□ Frequent cheek/lip biting
□ Plaque or tartar buildup
□ Pain in teeth or gums
□ Discolored/stained teeth
□ Crowding/crooked teeth
□ Spaces between teeth
□ Missing teeth
□ Tooth shape or size
□ Loose tooth/teeth
□ Unhappy with appearance of teeth
□ Too much gum tissue visible when I smile
□ Concerns with wisdom teeth
□ Food gets caught between teeth If yes, where?_____
□ Tooth sensitivity to hot, cold, sweets, biting or anything else
□ Broken teeth or restorations
□ Old fillings
□ Old crowns
□ Cavities (caries)
□ Loose or uncomfortable dentures If yes, date of placement_____
□ Bad breath
□ Bad taste in mouth
□ Dry mouth
□ Other_____

Please check any of the following you would like to discuss with the doctor.

□ Tooth whitening
□ Orthodontic treatment (braces)
□ Dental implants
□ New dentures
□ Veneers (cosmetic dentistry)
□ Tooth colored fillings
□ Tooth colored crowns
□ Preventing cavities
□ At home oral hygiene
□ Treatment during pregnancy
□ Oral hygiene for infants/toddlers
□ Preventing gum disease