



905 Calle Amanecer, Suite 265
 San Clemente, CA 92673
 (949) 388-0780
 OceanViewDentist.com
General & Cosmetic Dentistry

Patient Registration & Health History

Patient Name: _____ Birthdate: _____ Dr. Mr. Mrs. Ms.
 Single Married Social Security Number: _____-_____-_____ Driver's License Number: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (_____) _____ Cell Phone: (_____) _____ Email Address: _____
 Employer: _____ City: _____ Work Phone: (_____) _____
 Occupation: _____ Name of Spouse: _____
 Person Responsible for this Account: _____ Relation to Patient: _____ Dental Insurance? Yes No
How did you hear about our office? Yelp Google Mailer Referral _____ Other _____

Dental Information

What prompted you to seek dental care at this time? _____ _____	Are you completely satisfied with your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No
When was your last visit to a dentist? _____	Is there anything about the appearance of your smile/teeth that you would like to change? _____
What was done at your last visit? _____ _____	If there was a simple, inexpensive way to whiten your teeth, would you be interested? <input type="checkbox"/> Yes <input type="checkbox"/> No
Why are you changing dentists? _____ _____	How often do you brush your teeth? _____
Has the fear of discomfort kept you from regular dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss your teeth? _____
Have you lost any teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do your gums bleed when you floss? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have they been replaced by: <input type="checkbox"/> Fixed Bridge <input type="checkbox"/> Removable Partial <input type="checkbox"/> Implant <input type="checkbox"/> Denture <input type="checkbox"/> Nothing	Have you been told that you have Periodontal/Gum Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you happy with the replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had periodontal/gum treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any of your teeth sensitive to: <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Biting Pressure	Do you grind or clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had your teeth straightened (braces)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you aware of your jaw clicking or making grating-like noises? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you regularly wear your retainer after your braces? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had TMJ treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you suffer from halitosis (bad breath)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you snore or have difficulty falling or staying asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No

CONSENT: The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or \$4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account.

Patient (or Guardian) Signature: _____ Date: _____



Medical History

Family Physician's Name: _____ City: _____ Phone: (_____) _____

Have you had or currently have any of the following conditions?

	Yes	No		Yes	No		Yes	No			
Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, problem, or condition not listed? Yes No If Yes, what? _____

Are you currently under the care of a Physician? Yes No If Yes, why? _____

Are you currently taking any medication, drugs, or pills? Yes No If Yes, what? Please list below:

Do you have an allergy to local anesthetic? Yes No If Yes, what? _____

Do you have an allergy to any other medication(s)? Yes No If Yes, what? _____

Have you ever had a prescription for Bisphosphonate (Fosmax)? Yes No

Are you taking a blood thinner (Coumadin, Warfarin)? Yes No

Do you use tobacco products? Yes No

FOR WOMEN ONLY Are you pregnant? Yes No Are you taking Birth Control Pills? Yes No

Nearest Relative not living with you: _____ Relation: _____ Phone: (_____) _____

ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

Patient: X _____ Doctor: X _____ Date: _____

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Dental Insurance

IF YOU HAVE DENTAL INSURANCE: Please complete the following thoroughly. We can use this information to bill your insurance carrier automatically. This service is FREE to you. Our office will accept assignment of benefits if you sign the release below.

Primary Insurance	Secondary Insurance
Insured's Name: _____	Insured's Name: _____
Birthdate: _____	Birthdate: _____
Social Security Number: _____ - _____ - _____	Social Security Number: _____ - _____ - _____
Insurance ID Number: _____	Insurance ID Number: _____
Insurance Company: _____	Insurance Company: _____
Group/Local Number: _____	Group/Local Number: _____
Phone: (____) _____	Phone: (____) _____
Effective Date: _____ Relation to Patient: _____	Effective Date: _____ Relation to Patient: _____
Insured's Employer: _____	Insured's Employer: _____
City: _____ Time with Company: _____	City: _____ Time with Company: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my Insurance Company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent.

I understand that any amounts paid to this office are ESTIMATES only and I will not know the exact amount owed until my insurance has paid.

I further agree that should the amount paid by my insurance be insufficient to cover the entire dental expense, I will be responsible for payment of the difference.

Patient (or Guardian) Signature: _____ Date: _____