PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services.
To assist us in serving you, please complete both sides of this form.

Name_____ Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Preferred Name_____ SS #_____-____-_____ Driver's License #_____

Address_____ Occupation _____

City_____ State____ Zip_____ Employer/School _____

☐ Married ☐ Widowed ☐ Single ☐ Minor Employer/School Address _____

☐ Separated ☐ Divorced ☐ Partnered for ___ years Employer/School Phone _____

Spouse's name_____ Spouse's Employer _____

Date of Birth _____/_____/_____ SS # _____-____-_____ Spouse's Phone (____) _____

CONTACT INFORMATION

Cell (____) _____ Home (____) _____ Work (____) _____ Ext____

Email _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name_____ Relationship _____ Phone (___) _____

WHOM MAY WE THANK FOR REFERRING YOU?

☐ Doctor _____ ☐ Patient _____ ☐ Internet_____ ☐ Other _____

CANCELLATION POLICY

Your appointment is exclusively reserved for "You". If you are unable to keep your appointment please provide us with a 48-hour notice to avoid a late cancellation or missed appointment fee. _____
Initial

DENTAL INSURANCE

Primary Dental Insurance _____

Address _____

Phone (____) _____

Group # _____ Subscriber ID# _____

Subscriber Name _____

SS# _____-____-_____ Date of Birth _____/_____/_____

Employer _____

Secondary Dental Company _____

Address _____

Phone (____) _____

Group # _____ Subscriber ID# _____

Subscriber Name _____

SS# _____-____-_____ Date of Birth _____/_____/_____

Employer _____

_____ Signature of Patient/Parent/Guardian

_____ Please print name of Patient/Parent/Guardian

_____ Date

The Palisades Dentists

Dental History Form

Patient Name:_____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with dentists in the past? _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? Yes____ No___ If yes, please describe:_____

-If yes, would you like the dentists to only focus on the pain, or complete a full exam today? _____

Have you ever had to Pre-Medicate for dental treatment? Yes___ No ___ If yes, why? _____

Have you been anxious about having dental treatment? Yes ___ No ___

Would you like to discuss this concern with the doctor to learn about your relaxation/sedation options? Yes ___ No ___

Does food get caught in between teeth? Yes ___ No ___ If yes, where?_____

Difficulty chewing? Yes ___ No ___ If yes, where?_____

Have you ever had Orthodontic treatment? Yes ___ No ___ Do you wear a retainer? Yes ___ No ___

Are you interested in Whitening your smile? Yes ___ No __ Do you wear a nightguard? Yes ___ No ___

Other:_____

What concerns do you currently have with your oral health or smile? (Check All That Apply)

*Jaw Joint Pain	*Clenching or Grinding of Teeth	*Discolored Teeth
*Crowding/Crooked Teeth	*Missing Teeth	*Spaces in Between Teeth
*Loose Teeth/Tooth	*Tooth Shape or Size	*Unhappy with appeareance of teeth
*Overbite	*Underbite	*Old Fillings (gold or silver)
*Old Crowns	*Speech Problems	*Bad Breath
*Uncomfortable Bite	*Too much gum tissue when I smile	*Tooth Sensitivity to hot/cold

The Palisades Dentists

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
AIDS/HIV	___	___	**Epilepsy**	___	___	**Respiratory Disease**	___	___
Anemia	___	___	**Fainting / Dizziness**	___	___	**Rheumatic Fever**	___	___
Arthritis, Rheumatism	___	___	**Glaucoma**	___	___	**Scarlet Fever**	___	___
Artificial Heart Valves	___	___	**Headaches**	___	___	**Shortness of Breath**	___	___
Asthma	___	___	**Heart Problem**	___	___	**Sinus Trouble**	___	___
Back Problems	___	___	**Hepatitis Type ___**	___	___	**Skin Rash**	___	___
Abnormal Bleeding w/			**Herpes**	___	___	**Special Diet**	___	___
extraction or surgery	___	___	**High Blood Pressure**	___	___	**Stroke**	___	___
Blood Disease	___	___	**Jaundice**	___	___	**Swollen Feet or Ankles**	___	___
Cancer	___	___	**Jaw Pain**	___	___	**Thyroid Problems**	___	___
Chemical Dependency	___	___	**Kidney Disease**	___	___	**Tonsillitis**	___	___
Chemotherapy	___	___	**Liver Disease**	___	___	**Tuberculosis**	___	___
Circulatory Problems	___	___	**Low Blood Pressure**	___	___	**Tumor/Growth on Head/Neck**	___	___
Congenital Heart Lesions	___	___	**Mitral Valve Prolapse**	___	___	**Ulcer**	___	___
Cortisone Treatments	___	___	**Nervous Problems**	___	___	**Venereal Disease**	___	___
Cough Persistent/Bloody	___	___	**Pacemaker**	___	___	**Weight Loss**	___	___
Diabetes	___	___	**Psychiatric Care**	___	___	**Pregnant**	___	___
Emphysema	___	___	**Radiation Treatment**	___	___	**Nursing**	___	___

ALLERGIES:

Check off any and all that apply to you:

___ **Aspirin**
___ **Barbiturates (**Sleeping Pills**)**
___ **Codeine**
___ **Iodine**
___ **Latex or Rubber Dam**
___ **Local Anesthetic (**ex: Novocain**)**
___ **Penicillin**
___ **Metal**

other:_____

MEDICATIONS:

List any medications your are currently taking and the correlating diagnosis: _____

_____

_____

_____

Birth Control: Yes ___ No ___

Patient Signature/Guardian **Print name** **Date**

****Update Medical History:**

Any Changes in your medical history? No ___ Yes ___ Explain: _____

Patient Signature/Guardian Print name Date

*****Update Medical History:**

Any Changes in your medical history? No ___ Yes ___ Explain: _____

Patient Signature/Guardian Print name Date

The Palisades Dentists

FINANCIAL POLICY

• I understand it is my responsibility to pay the full amount for all dental treatment provided for my dependents and myself at the time of service.

• I understand that filing insurance claims is a courtesy that The Palisades Dentists extend to all patients and there are no guarantees of any estimated coverage or payments. The insurance company will directly reimburse any covered benefits to the responsible party.

• I understand that a $135 Broken Appointment Fee will be added to my account if I fail to provide at least 48-hour notice for cancelled or rescheduled dental appointments.

• I understand that it is my responsibility to advise the office of any changes in the information regarding my patient information, insurance and health history.

• I would like to know the fee in advance before any of my dental treatment is performed. ❑ Yes ❑ No

Signature: _____ Date: _____

Relationship:
❑ Self
❑ Parent or guardian
❑ Spouse
❑ Other _____

The Palisades Dentists

Consent and Acknowledgement for

Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning out Notice of Private Policies, please contact: The Office Administrator at (310) 459-2303.

Patient's Consent

I,_____, have read your Notice of Privacy Policies and consent to your use of my PHI for the purposes of healthcare operations, treatment and payment.

If this consent is signed by a personal representative on behalf of a patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature to revoke authorization: _____ Date: _____

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name: _____

Relationship to Patient: _____

The Federal HIPPA privacy compliance requirements are explained in this binder. When you develop your HIPPA compliance policy, incorporate whatever is necessary to address state law requirements as well.