# LONG BEACH DENTAL STUDIO
## Cosmetic & General Dentistry

We are pleased to welcome you to Long Beach Dental Studio. Please take a few minutes to fill out this form. If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your dental health and beautiful smile.

## Patient Information

Name: Last_____First_____MI_____Soc.Sec.#_____

Address_____City_____ State____ Zip_____

Sex: F M Age:_____ DOB: _____ Cell Ph: _____ Home Ph: _____

Email: _____ Whom may we thank for referring you? _____

Occupation: _____ Employer: _____

In Case Of Emergency Contact _____ Relationship _____ Phone #_____

## Dental Insurance

Person Responsible for Account _____ Subscriber's Address _____

Relationship to Patient: _____ Insurance Co. _____

Group # _____ Subscriber # _____ Phone # _____

Is the patient covered by additional Insurance? Yes No Insurance Co. _____

Subscriber's Name: _____ Relationship to Patient: _____

DOB: _____ SS# _____

Group # _____ Subscriber # _____ Phone# _____

## Dental History

Reason for today's visit _____ Last Visit _____

**Bleeding gums Y N** **Clicking/Popping jaw Y N** **Dry Mouth Y N** **Jaw pain Y N**
**Broken fillings Y N** **Pain around ears Y N** **Braces Y N** **Sores in mouth/lips Y N**
**Periodontal Treatment Y N** **Sensitivity to hot, cold, sweets, biting (circle all that apply)**

How often do you brush your teeth? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

What would you like to change?_____

# Medical History

Physician's name: _____ Phone # _____

Date of last visit _____ Have you had serious illness or operation? Y N If yes, describe _____

Are you currently under physician's care? Y N If yes, describe _____

**Women:** Are you pregnant ? Y N Nursing? Y N

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Y N | Anemia | Y N | Arthritis | Y N | Artificial joints | Y N | Asthma | Y N |
| Abnormal bleeding | Y N | Blood Disease | Y N | Diabetes | Y N | Cancer/Chemo/Rad | Y N | Jaw pain | Y N |
| Chemical dependency | Y N | Smoking | Y N | Emphysema | Y N | Fainting/dizziness | Y N | Stroke | Y N |
| Headaches | Y N | Heart murmur | Y N | Heart problems | Y N | Pacemaker | Y N | Sinus Trouble | Y N |
| Hepatitis A, B, C | Y N | Herpes/Cold sores | Y N | Low Blood Pressure | Y N | High Blood Pressure | Y N | Kidney Disease | Y N |
| Liver Disease | Y N | Psychiatric Care | Y N | Rheumatic Fever | Y N | Thyroid Problems | Y N | Tuberculosis | Y N |
| Fen-phen Drugs | Y N | Osteoporosis | Y N | Venereal Disease | Y N | Epilepsy | Y N | Mitral Valve Prolapse | Y N |

Do you have any disease, condition or problems not listed above that you think we should know about? Y N

Please explain: _____

**Medications:**

_____

_____

**Allergies:**

_____

_____

# Authorization

**I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform the dentist.**

**I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.**

**I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature _____ Date _____

# Future Visit Medical Updates

**Have there been any changes in your health since your last dental appointment? Y N**

Describe? _____ Medications? _____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

**Have there been any changes in your health since your last dental appointment? Y N**

Describe? _____ Medications? _____
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Doctor's Signature _____ Date _____

**Have there been any changes in your health since your last dental appointment? Y N**

Describe? _____ Medications? _____
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Doctor's Signature _____ Date _____