OCEAN VIEW DENTAL CARE
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: _____

Spouse's Employer: _____ City: _____ Work Phone: _____

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? _____

_____

When was your last visit to a dentist? _____

What was done at your last visit? _____

_____

Why are you changing dentists? _____

_____

Has the fear of discomfort kept you from regular dental visits? ❑ Yes ❑ No

Have you lost any teeth? ❑ Yes ❑ No

Have they been replaced by: ❑ Fixed Bridge ❑ Removable Partial ❑ Implant ❑ Denture ❑ Nothing

Are you happy with the replacement? ❑ Yes ❑ No

Are any of your teeth sensitive to: ❑ Heat ❑ Cold ❑ Biting Pressure

Have you had your teeth straightened (braces)? ❑ Yes ❑ No

Did you regularly wear your retainer after your braces? ❑ Yes ❑ No

Are you completely satisfied with your smile? ❑ Yes ❑ No

Is there anything about the appearance of your smile/teeth that you would like to change? _____

If there was a simple, inexpensive way to whiten your teeth, would you be interested? ❑ Yes ❑ No

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do your gums bleed when you floss? ❑ Yes ❑ No

Have you been told that you have Periodontal/Gum Disease? ❑ Yes ❑ No

Have you had periodontal/gum treatments? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Are you aware of your jaw clicking or making grating-like noises? ❑ Yes ❑ No

Have you ever had TMJ treatments? ❑ Yes ❑ No

Do you suffer from halitosis (bad breath)? ❑ Yes ❑ No

Do you snore or have difficulty falling or staying asleep? ❑ Yes ❑ 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		Yes	No
Heart Disease or Attack	❑	❑	High Blood Pressure	❑	❑	Hepatitis	❑	❑	Dry Mouth	❑	❑
Angina Pectoris	❑	❑	Stroke	❑	❑	Liver Disease	❑	❑	Radiation Therapy	❑	❑
Heart Murmur	❑	❑	Emphysema	❑	❑	Fainting or Dizzy Spells	❑	❑	Chemotherapy	❑	❑
Mitral Valve Prolapse	❑	❑	Diabetes	❑	❑	Heart Surgery	❑	❑	Psychiatric Care	❑	❑
Rheumatic Fever	❑	❑	Tuberculosis	❑	❑	Hemophilia	❑	❑	AIDS or HIV Positive	❑	❑
Artificial Heart Valve	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Asthma	❑	❑	Kidney Trouble	❑	❑
Heart Pacemaker	❑	❑	Arthritis	❑	❑	Thyroid Disease	❑	❑	Drug Addiction	❑	❑

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: _____