SOUTH COAST DENTAL CENTER

3500 S. Bristol St., Suite 101
Santa Ana, CA 92704

Date: _____

PATIENT INFORMATION

Patient: _____
Last Name First Name Initial Preferred Name

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Sex: M F Age: _____ Date of Birth: _____ Single Married Widowed Separated Divorced

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Date of Birth: _____

Spouse Employed by: _____ Spouse Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Patient's Social Security: _____ Spouse's Social Security: _____

Name of Dental Insurance Company: _____ Group Number: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (check boxes that apply):

Heart Problems	Headaches	Rheumatic Fever
High Blood Pressure	Hepatitis, Jaundice or Liver Disease	Sinus Problems
Low Blood Pressure	Cancer	"A.I.D.S." or other
Circulatory Problems	Psychiatric Care	Immunosuppressive Disorders
Nervous Problems	Chronic Diarrhea	Stroke
Radiation Treatment	Allergies to Anesthetics	Ulcer
Artificial Heart Valves or Joints	Allergies to Medicine or Drugs	Venereal Disease
Recent Weight Loss	General Allergies	Chemical Dependency
Back Problems	Blood Disease	Hemophilia
Diabetes	Arthritis	Respiratory Disease
Special Diet	Epilepsy	Swollen Neck Glands

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes No
If so, what medication: _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? Yes No If so, what medication: _____

Are you under the care of a physician? Yes No
For what conditions: _____

If patient is a child, what is his/her weight? _____

(Woman) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? _____

APPOINTMENT: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc, which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Should this account become past due, a finance charge of 1½% per month of the remaining balance will be added until the account is paid in full. Charges shown by statements are agreed to be correct and reasonable unless protest received in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs are the court determines proper.

I is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection hereof. (A copy of this assignment is as valid as the original.)

NOTICE: Do not sign the agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor investigation.

Signature: _____ Date: _____
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)

Signature of Doctor: _____ Date: _____

DENTAL HISTORY

Chief oral complaint: _____

Date of last exam: _____ Any previous major dental treatment: Yes No When _____

_____

Do you have or do you use any of the following – indicate with a ☑

Teeth sensitive to cold, heat, sweets or pressure	Bad breath	Cigarettes, pipe or cigar smoking
Bleeding gums, How long _____	Unpleasant taste	Texture of toothbrush _____
Food impaction	Unfavorable dental experience	Frequency of brushing _____
Clenching or grinding	Complications from extractions	Dental Floss
Burning of tongue	Periodontal treatment	Inter dental stimulators
Swelling or lumps in mouth	Orthodontic treatment	Water jet device
Frequent blisters on lips or mouth	Mouth breathing	Disclosing tablet or solution
Pain around ear	Oral habits, i.e., fingernail biting, cheek biting, etc.	Fluoride supplements

MEDICAL HISTORY UPDATE

Date	Medical Changes	Patient Signature	Doctor Signature