PATIENT INFORMATION SHEET

Name_____ Birthdate_____Today's Date_____

Residence_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

E-mail address_____Cell#_____

Soc. Sec. No. _____Driver's License No._____

If a Minor, Parent or Legal Guardian _____

Occupation _____

Patient Employed by _____Lenght of Employment _____

Employer's Address _____

Name of Spouse _____

Spouse Employed By _____

Person Responsible For this Account _____

Billing Address _____

_____

Do you have Dental Insurance ? Yes _____No _____

Name and Address of Insurance Carrier _____

_____

A Person not living with you who could be reached in case of an emergency :

Name _____Phone (Home)_____(Work)_____

Address_____

Whom may we thank for referring you?_____

PATIENT MEDICAL HISTORY

Medical Doctor's Name _____ Phone _____
Address _____

	Yes	No
Have you been seen by your medical doctor during the past year?	____	____
Have you ever been **hospitalized?**	____	____
If so, for what? _____		
Have you ever had **surgery?**	____	____
If so, please describe _____		
Have you had any serious accident involving **head injuries?**	____	____
Do you smoke?	____	____
Do you use smokeless tobacco?	____	____
Are you **allergic** to any drug or medications?	____	____
If so, please list _____		

Have you ever had any of the following?

Yes	No		Yes	No	
____	____	Heart Murmur	____	____	Joint Replacement
____	____	Mitral Valve Prolapse	____	____	Stroke
____	____	Heart Surgery	____	____	Diabetes
____	____	Heart Attack	____	____	Tumor or Growth
____	____	Angina	____	____	Hepatitis
____	____	Pacemaker	____	____	Kidney Disease
____	____	Artificial Heart Valve	____	____	Excessive Bleeding
____	____	Rheumatic Fever	____	____	Blood Transfusion
____	____	High Blood Pressure	____	____	Anemia
____	____	Low Blood Pressure	____	____	Fainting spells
____	____	Arrhythmias	____	____	Convulsions
____	____	Bacterial Endocarditis	____	____	Seizures
____	____	Other heart problems	____	____	Venereal Disease
____	____	Valve Replacement	____	____	HIV
____	____	Tuberculosis	____	____	AIDS
____	____	Emphysema	____	____	Chemical Dependency
____	____	Asthma	____	____	Chemotherapy
____	____	Shortness of Breath	____	____	Radiation Treatment

Are you now:

____	____	In good health
____	____	Pregnant
____	____	On a prescribed diet

Are you now taking:

____	____	Beta blockers
____	____	Anticoagulants
____	____	Immunosuppressants
____	____	Other medication

Please indicate any other information about your medical history which you feel may be important _____

DENTAL HISTORY

	Yes	No
Have you had orthodontic treatment? If yes. when? _____	____	____
Do you have un-replaced missing teeth?	____	____
Do your gums bleed when brushing your teeth?	____	____
Is any part of your mouth sensitive to temperature or pressure? If yes. what part? _____	____	____
Do you have any unpleasant odor or taste in your mouth?	____	____
Does food catch between your teeth? If yes. where? _____	____	____
Are you dissatisfied with your teeth and their appearance?	____	____
Do you clench or grind your teeth during the day?	____	____
Have you been made aware of clenching / grinding your teeth during the night?	____	____
Do you have chronic headaches or neck and shoulder pains?	____	____
Do you have headaches when you wake up?	____	____
Do you ever wake up with awareness of or about your teeth or jaw like you've had them clenched in your sleep?	____	____
Do you have any awareness of discomfort in the muscles of your neck or shoulders	____	____
Has your jaw ever locked?	____	____
Do you now or have you ever had pain in your jaw joint or the sides of your face (in and about the ears)?	____	____
Have you been diagnosed as having migraine headaches?	____	____
Do you have a clicking jaw joint or have you ever experience and inability to move your jaw or open your mouth wide?	____	____
Which side do you chew on? Right _____ Left _____ Both _____		
Have you ever had a bite splint or night guard?	____	____
If yes do you wear one now?	____	____
Do you have any dental complaints not specifically covered above?	____	____

When were your last dental X-rays taken? _____

If you think we might be able to obtain them please list the dentist's name and telephone number here: _____

_____

I have completed this pre-clinical examination questionnaire to the best of my knowledge.

Signature _____ Date _____

Reviewed by Dr. _____ Date _____

Financial Responsibility Consent

Roya E. Levi D.D.S
2409 Main Street
Santa Monica, CA 90405
310.392.8313

Date: _____

Patient: _____

Financially responsible party: _____

Our office will bill your insurance as a courtesy to you. Please be advised that some or all of the services rendered today may not be covered by your insurance, due to limitations of exclusions in your policy. Any residual balance after your insurance remits will be due and payable by the financially responsible party listed above.

Please be informed that we are going to add charges for return checks and/or collection costs.

Cancellation of missed appointments without 48 hours notice will incur a $70.00 fee.

We appreciate your cooperation.

Signature of financially responsible party. _____