Welcome to Oxnard Dentistry

In order to serve you properly, we need the following information.
All information is strictly confidential. ***(Please print clearly)*** Date:_____

GENERAL

Patient's Name:_____ Sex (M/F) _____ Birth date: _____
(First) (Last)

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

Home Phone No.: (___) _____ Work Phone No.: (___) _____ Cell No. (____) _____

Driving License No. _____ Soc. Sec. No.: _____ Referred By: _____

Email: _____ Occupation: _____ Marital Status: _____

Person Responsible for the Account – Name: _____
(First) (Last)

Relationship to Patient: _____ Birth Date: _____ Soc. Sec. No.: _____

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

Home Phone No.: (____) _____ Work Phone No.: (____)_____ Pager No.: (____) _____

DENTAL HISTORY

Chief Complaint / Reason for Visit:_____

When Was Your Last Dental Visit?_____ Last Full Mouth X-Ray? _____ Last Teeth cleaning?_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? – (PLEASE CHECK ALL THAT APPLY)

Teeth Sensitive to Cold, Heat, Sweet and Pressure	Teeth Grinding or Clenching	Broken or Chipped Tooth
Bleeding Gums? How Long? _____	Pain Around Ear, Neck & Shoulder	Finger Nail Biting, Cheek Biting
Food Impaction	Unusual Sounds in Ear While Eating	Frequency of Brushing _____
Bad Breath	Orthodontic Treatment	Dental Floss
Mouth Breathing	Periodontal Treatment	Water Jet Device
Cigarettes, Pipe or Cigar Smoking	Partial or Complete Denture	Professional Teeth Whitening

Are You Satisfied With Your Teeth's Appearance? _____

Please Add Anything You Feel Is Important: _____

INSURANCE

Do You Have Insurance or Dental Plan? Yes No Insurance Company Name: _____ Plan: _____

Employer: _____ Employer address and number: _____

Name of Insured: _____ Relationship to Patient:_____ Soc. Sec. No. _____

Do You Have Any Other Dental Insurance? Yes No If Yes, Insurance Company Name:_____ Plan:_____

I authorize the release of any medical/dental/personal information necessary to process dental claim, and I authorize payment of dental benefit to the Oxnard Dentistry for professional services rendered.

Signature: _____

I authorize the dental staff to perform any necessary dental service(s) with my informed consent that I may need during diagnosis and treatment. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. It is customary to pay for services when rendered, unless other arrangements have been made in advance. If account is not paid within 90 days of the date of service I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.
I acknowledge that I have received a copy of the "Dental Material Fact Sheet as required by law.
I acknowledge that I have received a copy of the "Notice of Privacy Practices".

Signature: _____