

# WILSHIRE SMILE STUDIO

the multi-specialty dental group

## PATIENT INFORMATION

### PATIENT NAME

FIRST: \_\_\_\_\_ MI: \_\_\_\_\_ LAST: \_\_\_\_\_ NICK NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SSN: \_\_\_\_\_  MALE  FEMALE

SINGLE  MARRIED  DIVORCED  WIDOWED EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL#: \_\_\_\_\_ WORK#: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? : \_\_\_\_\_

### EMERGENCY CONTACT

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PH#: \_\_\_\_\_

### RESPONSIBLE PARTY (IF SAME AS ABOVE, PLEASE SKIP)

FIRST: \_\_\_\_\_ LAST: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL#: \_\_\_\_\_ WORK#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

### EMPLOYMENT

EMPLOYER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_  PPO  HMO PH#: \_\_\_\_\_

MEMBER ID: \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURED NAME:  SELF  OTHER

IF OTHER, NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_  PPO  HMO PH#: \_\_\_\_\_

MEMBER ID: \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURED NAME:  SELF  OTHER

IF OTHER, NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_  PPO  HMO PH#: \_\_\_\_\_

MEMBER ID: \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURED NAME:  SELF  OTHER

IF OTHER, NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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## HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTION, CHECK YES OR NO AND FILL IN BLANK SPACES WHERE INDICATED.  
ANSWER TO THE FOLLOWING QUESTIONS, OUR RECORDS WILL BE CONSIDERED CONFIDENTIAL.

1. ARE YOU IN GOOD HEALTH? .....  YES  NO  
YOUR LAST PHYSICAL WAS ON: (DATE) \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_
2. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? .....  YES  NO  
A. IF SO, WHAT IS THE CONDITION BEING TREATED?: \_\_\_\_\_  
B. PHYSICIAN NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_
3. HAVE YOU EVER HAD A SERIOUS ILLNESS, OPERATION OR HAVE BEEN HOSPITALIZED?  
A. IF YES, FOR WHAT? \_\_\_\_\_ WHEN? \_\_\_\_\_
4. DO YOU DRINK ALCOHOLIC BEVERAGES? .....  YES  NO
5. HISTORY OF ALCOHOL ABUSE? .....  YES  NO
6. RECREATIONAL DRUGS IN THE LAST 6 MONTHS?  YES  NO
7. HISTORY OF DRUG ABUSE? .....  YES  NO
8. DO YOU SMOKE? .....  YES  NO
9. DO YOU USE TOBACCO? .....  YES  NO

### HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

#### HEART CONDITIONS

- HIGH BLOOD PRESSURE .....  YES  NO  
LOW BLOOD PRESSURE.....  YES  NO  
ANGINA / CHEST PAIN.....  YES  NO  
FAINTING OR SEIZURE.....  YES  NO  
IRREGULAR HEARTBEAT.....  YES  NO  
HEART ATTACK.....  YES  NO  
HEART BYPASS.....  YES  NO  
HEART PACEMAKER.....  YES  NO  
STROKE.....  YES  NO  
ANEMIA/ RHEUMATIC FEVER.....  YES  NO  
HEART VALVE DAMAGE .....  YES  NO

#### LIVER DISEASE

- HEPATITIS (CIRCLE A / B / C ) .....  YES  NO

#### BREATHING/ LUNG CONDITION

- ASTHMA .....  YES  NO  
ALLERGIES/ HAY FEVER.....  YES  NO  
BREATHING DIFFICULTIES.....  YES  NO  
SNORING / SLEEP APNEA.....  YES  NO  
TUBERCULOSIS.....  YES  NO  
SINUS PROBLEMS .....  YES  NO  
MENTAL HEALTH PROBLEMS.....  YES  NO

#### IMMUNOSUPPRESSED/BLOOD DISEASE

- HIV POSITIVE.....  YES  NO  
AIDS.....  YES  NO  
SEXUALLY TRANSMITTED DISEASE.....  YES  NO

DELAY IN HEALING.....  YES  NO

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## ORGAN CONDITION/ DISEASE

PANCREAS / DIABETES.....  YES  NO

KIDNEY/ DIALYSIS.....  YES  NO

EYES/ GLAUCOMA.....  YES  NO

THYROID.....  YES  NO

NEUROLOGICAL/ EPILEPSY.....  YES  NO

## CANCER

LOCATION: \_\_\_\_\_

SURGERY.....  YES  NO

## JOINT CONDITION

ARTHRITIS.....  YES  NO

ARTIFICIAL KNEE REPLACEMENT.....  YES  NO

ARTIFICIAL HIP REPLACEMENT.....  YES  NO

SWOLLEN ANKLES.....  YES  NO

OTHER: \_\_\_\_\_

CHEMO THERAPY.....  YES  NO

RADIATION TREATMENT.....  YES  NO

10. HAVE YOU HAD ANY DISEASE, SERIOUS ILLNESS/ SURGERY CONDITION OR PROBLEM NOT LISTED? .....  YES  NO  
IF YES, EXPLAIN: \_\_\_\_\_

11. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA? .....  YES  NO

12. DO YOU BRUISE EASILY? .....  YES  NO

13. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? .....  YES  NO  
IF YES, EXPLAIN CIRCUMSTANCES \_\_\_\_\_

14. HAVE YOU HAD SURGERY OR XRAY TREATMENT FOR A TUMOR, GROWTH OR OTHER CONDITION IN YOUR MOUTH OR LIPS?  
.....  YES  NO  
IF YES, WHEN? \_\_\_\_\_

15. HAVE YOU HAD ANY ADVERSE REACTION WITH PREVIOUS DENTAL TREATMENT? .....  YES  NO  
IF YES, EXPLAIN: \_\_\_\_\_

16. HAVE YOU HAD ANY ADVERSE REACTION ASSOCIATED WITH PREVIOUS MEDICAL PROBLEM? .....  YES  NO  
IF YES, EXPLAIN: \_\_\_\_\_

17. HAVE YOU BEEN ON ANY IV BISPHOPHONATES FOR CHEMOTHERAPY (I.E: ZOMETA), OR ORAL BISPHOSPHONATES IN THE  
LAST 5 YEARS FOR OSTEOPOROSIS (I.E: FOSAMAX OR ACTONEL)? .....  YES  NO  
IF YES, EXPLAIN: \_\_\_\_\_

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18. ARE YOU TAKING ANY DRUG OR MEDICINE? .....  YES  NO

IF YES, LIST ALL MEDICATION: \_\_\_\_\_

19. ARE YOU TAKING ANY OF THE FOLLOWING:

ASPIRIN.....  YES  NO

ANTIBIOTICS.....  YES  NO

SULFA DRUGS.....  YES  NO

MEDICINE FOR HIGH BLOOD PRESSURE...  YES  NO

TRANQUILIZERS.....  YES  NO

INSULIN .....  YES  NO

TOLBUTAMIDE.....  YES  NO

**DIGITALIS OR DRUGS FOR**

**HEART PROBLEMS** .....  YES  NO

**ANTIOCOAGULANTS.....**  YES  NO  
**(BLOOD THINNER)**

**CORTISONE (STEROIDS) ..** .....  YES  NO

**NITROGLYCERIN.....**  YES  NO

**OTHER:** \_\_\_\_\_

20. ARE YOU ALLERGIC OR HAVE REACTED  
ADVERSELY TO THE FOLLOWING:

**PENICILLIN** .....  YES  NO

**OTHER ANTIBIOTICS** .....  YES  NO

**ASPRIN** .....  YES  NO

**LATEX**.....  YES  NO

**LOCAL ANESTHETIC**.....  YES  NO

**IODINE**.....  YES  NO

**SULFA DRUGS**.....  YES  NO

**BARBITURATES, CODEINE, SEDATIVES ....**  YES  NO  
**OR SLEEPING PILLS**

**OTHER:** \_\_\_\_\_

## WOMEN ONLY

**ARE YOU TAKING BIRTH CONTROL?** .....  YES  NO

**ARE YOU PREGNANT?** .....  YES  NO

**ARE YOU NURSING/BREASFEEDING?** .....  YES  NO

NOTE: ANTIOTIOTICS (SUCH AS PENICILLIN)  
MAY ALTER THE EFFECT OF BIRTH CONTROL PILLS. CONSULT YOUR  
PHYSICIAN/GYNECOLOGIST FOR ASSITANCE REGARDING ADDITIONAL

I HAVE FILLED OUR THIS QUESTIONNAIRE COMPLETELY, I HAVE ADVISED AND WILL ADVISE IN THE FUTURE TO WILSHIRE SMILE STUDIO ALL MEDICAL PROBLEMS OF WHICH I AM AWARE OF.

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

(PARENT/GUARDIAN IF MINOR)

DOCTOR'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

NOTES: \_\_\_\_\_

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## Our Commitment

*We feel it is important to share information with you on “how and why” our practice prides itself on spending quality time with each individual patient and provide quality dentistry at reasonable costs. We do this by having the office staff and patients acknowledge and abide by certain commitments.*

### COMMITMENT TO TREATMENT POLICY

In most cases, we believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and additional expenses. Therefore, if a plan is agreed upon and started, it, in most cases, should be completed. Rest assured that we would never move forward with treatment without your consent. We ask that you consent to discuss finances over the phone, email and mail. We are more than happy to send you or another dental provider your dental images for a \$35 fee.

### COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice and rarely keep patient waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you promptly and that you will be present for that appointment. Our answering machine does not accept appointments cancellations or changes. We must have mutual respect for each other's time. We must charge a cancellation fee of \$50 per hour of schedule treatment if less than 72 hours' notice of cancellation is not given.

### COMMITMENT TO FINANCIAL AGREEMENT POLICY

We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We will not move forward with treatment unless you are fully aware of fees and expected payment and then only with your consent. There will be a \$35 fee for all returned or stopped checks after services are rendered. If you have an overdue balance and if we send your account to collections, we need to charge an interest rate of 10% from the date of delinquency (delinquency is a balance 30 days overdue from the date of billing) and if there was any courtesy adjustment, it will be reserved and full balance owed.

### INSURANCE POLICY

Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember that we work 100% for you, not your insurance company. Your dental plan may only cover charges for the least expensive results. We refuse to compromise our standards by offering anything less than the complete care that you deserve. We will file insurance claims as a courtesy to you. Please understand that YOU are ultimately responsible for any amounts not covered by your insurance plan. You give us the authorization assign all medical and dental payments from your insurance to us directly. You understand that you are financially responsible for all the charges not covered or paid by your insurance for whatever reason.

I have read and thoroughly understand the above statements.

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

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**RECEIPT OF DENTAL MATERIAL FACT SHEETS AND NOTICE OF PRIVACY PRACTICES**

- As of January 1, 2002, the Dental board of California now requires that we provide to our patients a copy of the Dental Material Fact Sheets (DMDS).
- As of April 14, 2003, the Health Insurance Portability and Accountability Act (HIPAA), we provide to our patients a copy of our Notice of Privacy Practices.

I, \_\_\_\_\_, the undersigned, acknowledge that I have read the MSDS and HIPAA documents. Please inform the staff if you like copies for your file.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

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## DENTAL EVALUATION

NAME: \_\_\_\_\_

1. Reason for your visit today? \_\_\_\_\_
2. Date of last dental visit: \_\_\_\_\_
3. Name of previous dental office/dentist: \_\_\_\_\_
4. Do your gums bleed when you brush? \_\_\_\_\_
5. How often do you floss? \_\_\_\_\_
6. Have you or a family member ever been treated for periodontal disease? .....  YES  NO
7. Have you ever had an oral cancer screening? .....  NO  YES
  
8. Have you ever had complications from an extraction? .....  YES  NO
9. Have you ever had popping or clicking near your ear when you chew? .....  YES  NO
10. Are you prone to frequent headaches? .....  YES  NO
11. Do you grind or clench your teeth? .....  YES  NO
12. Do you have sores, blister or swelling on your gums, lips or cheeks? .....  YES  NO
13. Have you ever had orthotic treatment? .....  YES  NO
14. Do you snore? .....  YES  NO
  
15. Do you have problems with bad breath? .....  YES  NO
16. Have you ever had an allergic reaction to a crown, metal filling or dental appliance? .....  YES  NO
17. Have you ever used an electric toothbrush? .....  YES  NO
18. Are your teeth sensitive to hot, cold or pressure? .....  YES  NO
19. Do you like the appearance of your smile? .....  YES  NO
20. On a scale of 1-10, with 10 being the highest, how important is your dental health to you? \_\_\_\_\_
  
21. If you could change something about your smiles what would it be?
  - WHITER
  - STRAIGHTEN
  - CLOSE SPACE
  - REPAIR CHIPPED TOOTH
  - REPLACE MISSING TEETH
  - REPLACE OLD CROWNS THAT DO NOT MATCH
  - REPLACE OLD BLACK MERCURY FILLINGS
  - OTHER: \_\_\_\_\_

