Serenity Dental Care

11262 Washington Blvd

Culver City, CA 90230

(310 390-6500

Today's Date ____

PATIENT INFORMATION

Name ____

Last First Middles

Birthdate ________________ Age _____ male female

single married divorced widowed separated

Home Address ____

____

Home # ________________________ Cell #_____________________

Work #_________________ Ext ______ Other _____________________

Email ____

Driver's License __________________ SS# _______________________

Employer ____

Employer's Address ____

Occupation __________________________ How long held ___________

How did you find us __________________________________ If referred,

Who may we thank for referring you?_____________________________

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name ____

Insurance Co Address ____

Insurance Co. Phone # ____

Group # (Plan, Local, or Policy#) ______________________________

Insured's Name _______________________ Relation_________________

Insured's Birthday __________________ Insured's SS# _______________

Insured's Employer ____

SECONDARY DENTAL INSURANCE

Insurance Co. Name ____

Insurance Co Address ____

Insurance Co. Phone # ____

Group # (Plan, Local, or Policy#) ______________________________

Insured's Name _______________________ Relation_________________

Insured's Birthday __________________ Insured's SS# _______________

Insured's Employer

In the event of an emergency, is there someone who lives near you that we can contact?

Name ___________________________ Relationship _______________________

Home # ________________________ Cell # ______________________________

Work # ________________________ Ext __________________

DENTAL HISTORY

Have you ever had local anesthetic? yes no

Have you ever had any unfavorable reaction from a local anesthetic? Yes No

If yes, please explain____

Have you had any serious trouble associated with any previous dental treatment?

Yes No, If yes, please explain ______________________________________

____

Do you like the appearance of your teeth and smile? Yes No, If not, please

Explain ____

____

Do you like the color of your teeth? Yes No, If not please explain __________

____

Do you have spaces that you don't like? Yes No, If yes, please explain ______

____

Are there any old fillings or dental work that you don't like looking at? Yes No

If yes, please explain ____

Yes No (If yes, please explain)

sensitive teeth to cold or heat. Explain ________________________ _____

teeth sensitive to sweets. Explain ___________________________________

bleeding gums. Explain____

food impacting. Explain ____

pain around ear. Explain____

bad breath. Explain____

clenching or grinding. Explain_______________________________________

dry mouth. Explain____

swelling or lumps. Explain____

unpleasant taste. Explain____

sore jaw. Explain____

play sports. Explain____

wear a nightguard / occlusal guard

MEDICAL HISTORY

Personal Physician Name ________________________________

Address ____

Phone # _______________________ Fax #__________________

Your current health is good fair poor

Are you under the care of a physician? yes no If yes,

please explain ____

Have you ever had any serious illness or operation? yes no

If yes, please explain____________________________________

Have you ever been hospitalized? yes no If yes, please

explain ____

Are you taking any medications drugs herbs

If so, what? ____

____

Are you using any recreational drugs (marijuana, cocaine, etc)?

yes no If so, what? ______________________________

Have you ever been premedicated with antibiotics for your dental treatment? yes no

Do you smoke or chew tobacco? yes no

For women Are you taking birth control pills? yes no

Are you pregnant? yes no If yes, how many months? ____

Are you nursing? yes no

Are you allergic to any drugs or materials? yes no

penicillin aspirin sulfa drugs

tetracycline codeine latex

Erythromycin

Please list any other allergies ___________________________

____

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Do you have the following: (Please circle **Y** for Yes and **N** for no)

Y N Chemotherapy	Y N Herpes	Y N Head Injuries
Y N Ulcers	Y N Diabetes	Y N Tumors or Growths
Y N Asthma	Y N Cancer	Y N Seizures/Epilepsy
Y N Hay Fever	Y N Glaucoma	Y N Tonsillitis
Y N Hemophilia	Y N Cold Sores	Y N Chicken Pox
Y N Emphysema	Y N Rheumatism	Y N Bruise Easily
Y N Stroke	Y N Heart Failure	Y N Scarlet Fever
Y N Sinus Trouble	Y N Heart Murmur	Y N Liver Disease
Y N Blood Disease	Y N Heart Ailments	Y N Heart Attack
Y N Cerebral palsy	Y N Drug Addiction	Y N Kidney Disease
Y N Radiation Treatment	Y N Stomach Ulcers	Y N Angina Pectoris
Y N Mental Disorder	Y N Thyroid Disease	Y N Fainting Spells
Y N Rheumatic Fever	Y N Tuberculosis (T.B.)	Y N Blood Transfusion
Y N Joint Replacement	Y N Nervous Disorders	Y N Arthritis
Y N Allergies or Hives	Y N Pain in jaw joints	Y N Artificial Prosthesis
Y N AIDS/HIV	Y N respiratory disease	Y N TMJ Disorder
Y N Psychiatric	Y N High Blood Pressure	Y N Hepatitis/Jaundice
Y N Sickle cell disease	Y N Cortisone Medicine	Y N Difficulty swallowing
Y N excessive bleeding	Y N Mitral Valve Prolapse	Y N Anemia
Y N Venereal Disease	Other_________________________	

Are you taking Bisphosphonates? yes no

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be he in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I herby grant authority to the dentist(s) in charge of the care of the patient whose name appears on thi Health History form, to administer such anesthetics and analgesic; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs

Authorization must be signed by the patient, or by the nearest relative in the case of minor or when the patient is physically or mentally incompetent.

____

Patient's Signature/Guardian Date

____

Doctor's Signature Date