Patient Information

Patient Name: _____ Date: _____
Last First MI (preferred name)
Gender:_____ Family Status:_____(Single, Married, Child)
Social Security #: _____ Birth Date: _____
Phone (Home): _____(Work): _____(Cell): _____
Email address_____
Address: _____
Street Apartment #
_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

- Name of physician:_____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____
_____

Please list any medications you are currently taking:_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I agree to pay all fees charged for services rendered. I also understand all fees are due and payable at the time of service.

I further understand that Santa Clarita Valley Dental Care will be billing any insurance as a courtesy and that I am financially responsible for any portion not covered by my insurance. Any disputes in regard to insurance benefits are my responsibility. Santa Clarita Valley Dental Care will provide all needed informtiaon to my insurance carrier to assist me to resolve disputes as quickly as possible.

I understand that the office requires a 24-hour notice cancellation for all dental appoints. A fee will be charged to my account for any appointment not cancelled within that time. I understand I will be responsible for that fee.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

□Another patient, friend □Another patient, relative □Dental Office □Yellow pages □Insurance Company
□Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: □ the patient's spouse □ the patient's parent □ the patient's legal guardian □ the person responsible for payment

Name: _____

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____(Cell): _____

Address: _____
Street apartment #

_____
City State Zip Code

Employment Information

The following is for: □ the patient □ the person responsible for payment

Employer Name: _____ Occupation: _____

Address _____

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? □ Yes □ No
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #:_____

Insured's Address:

_____
Street City State Zip Code

Insured's Employer Name:

_____

Address:

_____
Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address:

_____

_____

Secondary

Name of Insured:_____ Is insured a patient? □ Yes □ No
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

_____