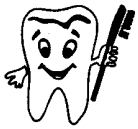

UPLAND SMILE CENTER

PATIENT INFORMATION

This information is necessary for our files and will be considered **CONFIDENTIAL**

(BLACK INK ONLY)

Today's Date_____ Male Female

Patient's Name_____Age_____Date of Birth_____
Last First M.I. month-day-yr

Patient's Address _____
Street Apt. # City State Zip

Relationship to Patient – (circle one please) Self Spouse Parent Legal Guardian

Home Phone # _____ Patient is (circle one please) Single Married Divorced Widowed
Cell Phone # _____

Social Security # _____-____-_____ Drivers License # _____ Email Address : _____

Occupation_____ Employed by:_____

Employer Address _____Work Phone #_____

Person to Notify in case of emergency:_____Phone#_____ Relationship to patient: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insured _____ Social Security # _____-____-_____Date Of Birth_____
Last First M.I.

Employer _____ Driver's License #_____

Employer Address _____ Phone #_____

Insurance Company _____ Insurance Co. Phone # _____

Plan/Group Number _____ Policy # /Medi-Cal I.D. #_____

DUAL INSURANCE INFORMATION

Secondary Insured_____ Social Security # _____-____-_____ Date Of Birth_____
Last First M.I.

Employer _____ Driver's License #_____

Employer Address _____ Phone #_____

Insurance Company _____ Insurance Co. Phone # _____

Plan/Group Number _____ Policy # /Medi-Cal I.D. #_____

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, Upland Smile Center cannot render services on the assumption that charges will be paid by an insurance company.

ASSIGNMENT OF INSURANCE- I hereby authorize my insurance company to pay directly to Upland Smile Center benefits accruing to me under my policy.

I grant my permission to Upland Smile Center and its assigns, to telephone me at home or at work, to discuss matters related to this form.

I have read and understood the above conditions of treatment, and agree to their content:

Signed_____ Date_____

General Health Information

1. Are you under a Doctors care at this time? (Please circle) **YES NO**
2. Are you taking any medication? **YES NO** if yes, please specify medication and dosage:_____
3. Are you sensitive or allergic to any drugs? (Please circle) Penicillin; Tetracycline; Codeine; Sulfa Drugs; Aspirin; others please specify:_____
4. Are you or have you used any recreational drugs? (Marijuana, cocaine, etc) **YES NO if** yes, please specify_____
5. Have you ever been pre-medicated with antibiotics for your dental treatment? **YES NO**
   If yes please specify medication and dosage: _____
6. Do you have or have you had any of the following: (please circle)

ANEMIA	HEMOPHILIA	HEART MURMUR	TUBERCULOSIS(TB)	CORTISONE MEDICINE	HEART ATTACK
HERPES	COLD SORES	LIVER DISEASE	RHEUMATIC FEVER	ALLERGIES TO METALS	CONGENITAL HEART LESIONS
STROKE	EMPHYSEMA	BLOOD DISEASE	BLOOD TRANSFUSION	EXCESSIVE BLEEDING	COBALT TREATMENT
ULCERS	RHEUMATISM	DRUG ADDICTION	JOINT REPLACEMENT	HIGH BLOOD PRESSURE	FAINTING, OR SEIZURES
DIABETES	CHICKEN POX	KIDNEY DISEASE	NERVOUS DISORDERS	HIV RELATED COMPLEX	CANCER
ARTHRITIS	ALLERGIES	HIVES	ANGINA PECTORIS	MITRAL VALVE PROPLAPSE (MVP)	
HAY FEVER	AIDS	YEAST INFECTION	VENEREAL DISEASE	RESPIRATORY DISEASE	CEREBRAL PALSY
HEPATITIS	JAUNDICE	ASTHMA	TONSILITIS	SCARLET FEVER	MEASLES
GLAUCOMA	SMALL POX	CHOLERA	TUMORS	LOW BLOOD PRESSURE	HEART BYPASS
DIARRHEA	THYROID DISEASE		BLISTERS	ARTIFICIAL PROSTHESIS	MENTAL DISORDER
OTHER _____				TMJ (Temporomandibular Joint)	

7. Do you wear a cardiac pacemaker or have you had heart surgery? **YES NO** If yes, when?_____
8. Do you have any disease, condition or problem not listed that we should know about? **YES NO** If yes please specify_____
9. Do you smoke? **YES NO** If yes, how much?_____
10. (Women) Are you pregnant or is there a possibility that you might be pregnant? **YES /NO** If yes, how many months?____
11. (Women) Do you have any problems associated with your menstrual period? **YES NO**
12. (Women) Do you take birth control pills? **YES NO**
13. Are you taking or have you taken any type of diet medication? **YES NO** If YES please specify**:_____**
14. Are you taking or have you taken any type of bisphosphonate medications? **YES NO** If YES please specify**:_____**

DENTAL HISTORY

1. Why are you here today? (Please circle) CHECKUP CLEANING TOOTHACHE FILLING OTHER_____
2. When was your last Dental Visit? _____ Treatments performed_____
3. Was the treatment completed? **YES NO**
4. Have you had any problems with past dental treatments? **YES NO** If yes, please specify_____
5. How long since your last full mouth X-rays?_____
6. Does dental treatment make you nervous? ____No ___ Slightly _____ Moderately _____ Extremely
7. Do your gums bleed easily? **YES NO**
8. Do you feel you have bad breath? **YES NO**
9. Have you had any allergic reaction to local anesthetics or latex gloves? **YES NO** If yes, please specify_____

THESE QUESTIONS ARE FOR YOUR BENEFIT, AND ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT REST ASSURED THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTH CARE.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment. **Please initial_____**

A. Date_____ Signature_____ Doctors Initial_____
Changes in health since last visit _____
B. Date_____ Signature_____ Doctors Initial_____
Changes in health since last visit _____
C. Date_____ Signature_____ Doctors Initial_____
Changes in health since last visit _____

	A	**B**	**C**
Date	_____	_____	_____
BP	_____	_____	_____
Pulse	_____	_____	_____
Temp	_____	_____	_____
By	_____	_____	_____

Health Questionnaire MUST be continually updated!

CONSENT FOR TREATMENT

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics sedatives, nitrous oxide sedation, 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.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Signed:_____Date_____
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is mentally and physically incompetent.
Relationship to patient_____Doctors Signature:_____Date:_____