GREAT SMILES
OF LA MESA

We would like to get to know you better!

Patient Name _____
Last First Middle
If Patient is a minor, state name of parent of legal guardian_____ Relationship _____
Residence Address _____
Street City Zip
Email Address _____
Mobile Number _____ Residence Number _____ Work Number _____
Social Security Number _____ Date of Birth _____ Drivers License Number _____
Employed by _____ How Long _____ Occupation _____
Business Address _____
Street City Zip
Marital Status _____ Spouse's Name _____ Spouse's Number _____

Insurance Information

Person responsible for this account _____ Relationship _____
Billing Address _____ Phone _____

Name of insurance company (Primary Insurance) _____
_____
Insured Persons Name Birth Date Relationship Social Security #
_____
Name of Group Dental Plan Group # Plan # Name of Union Local

Name of insurance company (Secondary Insurance) _____
_____
Insured Persons Name Birth Date Relationship Social Security #
_____
Name of Group Dental Plan Group # Plan # Name of Union Local

Are your teeth sensitive to	Yes	No		Yes	No
Heat?	❑	❑	Do you ever avoid any part of the mouth while brushing?	❑	❑
Cold?	❑	❑	Have you had a reaction to local anesthetic?	❑	❑
Sweets?	❑	❑	Are you dissatisfied with your teeth & their appearance?	❑	❑
Does your food get caught between your teeth?	❑	❑	Have you noticed any gum swelling around any teeth?	❑	❑
Do your gums bleed when brushing?	❑	❑	Do you smoke? If so, how often _____	❑	❑
Do you have an unpleasant taste or odor in your mouth?	❑	❑	Have you had any teeth removed/oral surgery?	❑	❑
Have you ever had dry mouth?	❑	❑	Have you ever had orthodontic treatment or braces?	❑	❑
Do you have Dental Implants?	❑	❑	Do you have any dental fears?	❑	❑
Problems of the Jaw:			When was your last dental appointment? _____		
Clicking of the Jaw	❑	❑	Are you interested in brightening your smile?	❑	❑
Pain (Joints. Ear, side of face)	❑	❑	Are you interested in straightening your teeth?	❑	❑
Difficulty opening or closing	❑	❑	How did you hear about us? Circle all that apply:		
Difficult chewing	❑	❑	Yelp Google Insurance		
			Office sign Friend/Family Name: _____		

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NOTICE OF PRIVACY PRACTICES

It is federal and state law to maintain the privacy of your health information. This law (HIPAA) requires us to give you this notice about our privacy practice, our legal obligations, and your rights concerning your health.

Uses and Disclosure of Health Information:

We may use and disclose information about your health for the following reasons

I. Treatment purposes: To another dentist, physician or health care provider
II. Payment purposes: To an insurance company, plan administrator or collection agency
III. Friends and family: To help pick up prescriptions, medical supplies, x-rays or health related activities, in the event of contingencies
IV. Appointment reminders: To use aides like voicemail, e-mails, letters, marketing, etc.
V. Public benefit: As required by law, to report abuse or domestic violence, to health agencies or a court of law, law enforcement officials, military and other federal officials and state workers compensation laws.

Patient Rights:

You may request copies of your health information by making a request in writing. Your health information will be kept for a minimum of 6 years; you have the right to request that we amend your health information.

We support your right to the privacy of your health information and we will do everything within our means and reasonable bounds to enforce this.

Patient Name:_____
Last First Initial

Phone: _____ E-mail: _____

I acknowledge that I have received a Notice of Privacy Practice from the above – mentioned office.

_____
Signature of Patient (Parent if Minor) *Date*

BROKEN APPOINTMENT OFFICE POLICY

This appointment has been reserved for you exclusively on our schedule. While unexpected situations may occur from time to time that may cause you to cancel your reserved appointment, please be informed that any appointments cancelled within less than a 48 hour notification, or failure to show for your reserved appointment will result in a $10.00 charge for every 15 minutes of your reservation. The broken appointment fee will need to be paid in full before rescheduling another appointment.

_____
Signature of Patient (Parent if Minor) *Date*

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Are you in good general health? ❑ ❑

Your Physician's Name _____ Address _____ Phone _____

Are you being treated for any illness now? ❑ ❑

If yes, please describe: _____

Are you taking medications, drugs or pills now? ❑ ❑

If yes, please describe: _____

Are you aware of having allergic reactions to any medication or substances? ❑ ❑

If yes, please describe: _____

Have you been hospitalized during the past five years? ❑ ❑

If yes, please describe: _____

Indicate which of the following you have had, or have at present

	YES	NO		YES	NO		YES	NO
Heart Disease, Surgery, Attack	❑	❑	Swollen Ankles	❑	❑	Cancer	❑	❑
Heart Defect	❑	❑	Fainting, Dizzy Spells	❑	❑	Chemotherapy	❑	❑
Artificial Heart Valve	❑	❑	Stroke	❑	❑	Tumors	❑	❑
Heart Murmur	❑	❑	Diet	❑	❑	Venereal Disease	❑	❑
Congenital Heart Disease	❑	❑	Kidney Trouble	❑	❑	AIDS	❑	❑
Mitral Valve Prolapse	❑	❑	Ulcers	❑	❑	H.I.V. Positive	❑	❑
Rheumatic Fever	❑	❑	Diabetes	❑	❑	Fever Blisters	❑	❑
High Blood Pressure	❑	❑	Thyroid Problems	❑	❑	Cold Sores	❑	❑
Chest Pain	❑	❑	Glaucoma	❑	❑	Blood Transfusion	❑	❑
Heart Pacemaker	❑	❑	Contact Lenses	❑	❑	Hemophilia	❑	❑
Artificial Joints	❑	❑	Hay Fever	❑	❑	Sickle Cell Disease	❑	❑
TB, Emphysema	❑	❑	Latex Sensitivity	❑	❑	Bruise Easily	❑	❑
Chronic Cough	❑	❑	Allergies or Hives	❑	❑	Liver Disease	❑	❑
Asthma	❑	❑	Sinus Trouble	❑	❑	Yellow Jaundice	❑	❑
Arthritis, Rheumatism	❑	❑	Hepatitis	❑	❑	Epilepsy, Seizures	❑	❑
Cortisone Medication	❑	❑	Radiation Therapy	❑	❑			
Psychiatric, Psychological Care	❑	❑	Bisphosphonate (fosamax,boniva, etc)				❑	❑
			Diet Drug Use (Phen-Fen, Rudux, Pondium)				❑	❑
Recreational Drugs	❑	❑	If yes, how much? _____					
Alcohol	❑	❑	If yes, how much? _____					

Have you lost or gained more that 10 pounds in the past year? ❑ ❑

Do you have or have you had any disease, condition or problem not listed? ❑ ❑

If yes, please describe: _____

Women	YES	NO		YES	NO		YES	NO
Are you pregnant?	❑	❑_____ Months	Are you nursing?	❑	❑	Are you taking birth control?	❑	❑

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature of Patient or Parent _____ Date _____ Dr. Initials_____

Signature of Patient or Parent _____ Date _____ Dr. Initials_____

Signature of Patient or Parent _____ Date _____ Dr. Initials_____

I have read the Materials Fact Sheet by the Dental Board of California.

Signature of Patient or Parent _____ Date _____