THE BEVERLY HILLS CENTER
FOR AESTHETIC AND RESTORATIVE DENTISTRY

Patient Registration

First Name: ________________________________ Last Name: ______________________ Middle Initial: ________

Preferred Name: ___________________ Who May We Thank for Referring You? ___________________________

Patient is : ◻ Responsible Party

Patient Information:

Address: ___________________________________ Address 2: ____

City, State, Zip: ____

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: _____________________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ______________________ Social Security #: _____________________ Drivers Lic#: ____________________

E-mail: _____________________________________ ◻ I would like to receive email correspondences

Consent Information

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that I can ask for a complete recital of any possible complication. I understand that using anesthetics agents embodies a certain risk. Furthermore, I authorize and consent that Doctor choose and employ such assistance as deemed fit provide recommended treatment.

To avoid any misunderstandings regarding your dental insurance, we wish our patients to know ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We do not render services on the basis that the insurance companies will pay our fees. Our office will provide you with insurance receipts so that you can bill your own insurance company. We will be available to assist you in any way we can. PAYMENT IS DUE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. In the event payment are not received by agreed-upon dates, I understand that a 1-1/2% charge (18APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature____**Date**_____________________

Witness____

Parent/Responsible Party's Signature_________________________ **Relationship to Patient** ___________________

MEDICAL HISTORY

PATIENT NAME ____ Birth Date _____________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: ____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes, please explain: ____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: ____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	High Cholesterol	Yes	No
Osteoporosis	Yes	No									

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ____
____
____

Comments: ____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____ DATE _____________________

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care

Please complete medical/dental history form.

All information is completely confidential

What is the reason for your visit today?____

____

Date of Last Dental Visit__________Last Dental Cleaning__________Last Full Mouth Xrays__________

What was done at your last dental visit?____

Previous Dentist's Name____

Address______________________State__________Zip__________

Telephone____

How often do you have dental examinations?____

How often do you brush your teeth?____________________How often do you floss?____________________

Have you ever used or are currently using topical fluoride? Yes__No__

What other dental aids do you use?(Interplak, toothpick, etc.)

Do you have any dental problems now? Yes____No_____

If yes, please describe:____

Are any of your teeth sensitive to:

Hot and cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No
If yes, where?__________		
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause__________		
Have you experienced:		
Clicking or popping of the jaw? Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles(neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment? If so, what is your biggest concern? __________	Yes	No
Have you ever had an upsetting dental experience? If yes, please describe__________	Yes	No

Have you ever been told to take pre-medication prior to dental treatment? Yes No

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe____

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Dental Materials Consent Form

I, ___________________________________have reviewed the Dental Materials Fact Sheet from The Dental Board of California informing me of the most frequently used materials in restorative dentistry. I understand the potential safety and/or health risks associated with various materials.

Signed:_____________________________________Date:__________

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with, the notice of our legal duties and privacy practices with respect to protect health information.

I,________________________________Acknowledge Receipt of

Notice of Private Practices

Signed:_____________________________________Date:__________

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