San Diego Dental Health Center

Perlman Medical Offices-9350 Campus Point Drive-Suite 1D La Jolla, CA
p. 310-307-6623 sandiegodentalhealthcenter@gmail.com

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient Name: _____ _____ _____ **Date Of Birth:** _____
First, Last, Middle (Preferred)

Social Security #: _____ **Gender:** ☐Male ☐ Female **Family Status:** ☐Married ☐Single

Home#:_____ **Work#** _____ **Ext:** _____**Cell#:**_____

Address: Street _____ Apartment # _____

City _____ State _____ Zip Code _____

Email Address: _____

Patient Health History

Have you ever had, or now have any of the following? Please check all that apply:

___ AIDS
___ Allergies
___ Allergy – Aspirin
___ Allergy- Latex
___ Allergy – Codeine
___ Allergy – Erythro
___ Allergy – Penicillin
___ Allergy – Hay Fever
___ Allergy – Sulfa
___ Allergy – Other _____
___ Anemia
___ Arthritis, Rheumatism
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___Bleeding abnormally, with extractions or surgery
___Blood Disease
___ Cancer
___Chemical Dependency
___Chemotherapy
___Congenital Heart Lesions
___Diabetes
___Dizziness
___Epilepsy
___Fainting
___Glaucoma
___Head Injuries
___Headaches or Migraines
___Heart Problems
___Hepatitis : Type _____
___Herpes
___High Blood Pressure
___HIV
___Jaundice
___Kidney Disease
___Liver Disease
___Low Blood Pressure
___ Mitral Valve Prolapse
___ Mental / Nervous Disorders
___Pacemaker
Women: Are you pregnant?
Due Date : _____
___Psychiatric Care
___Radiation Treatment
___Respiratory Problems
___Rheumatic Fever
___Sinus Problems
___Stomach Problems
___Stroke
___Swollen Neck Glands
___Thyroid Problems
___Tuberculosis
___Tonsillitis
___Tumor or growth on head or neck
___Ulcer
___Venereal Disease
Other: _____

Are you currently taking any medications or substances? ☐ **Yes** ☐ **No**

If yes, please list: _____

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

If yes, please list: _____

Name of physician: _____ **Phone:** _____

Do you have any health problems that need further clarification? ☐ **Yes** ☐ **No**

If yes, please explain: _____

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.

Signature of patient/ Parent or guardian: _____ **Date:** _____

Responsible Party Information

The following is for: ☐The patient's spouse ☐ The person responsible for payment ☐Guarantor of insurance

Name:_____ **Date of Birth:** _____

Social Security #:_____ **Gender: ☐Male ☐Female Family Status: ☐Married ☐Single**

Home Phone: _____ **Work:** _____ **Ext:** _____ **Best time to call:** _____

Address: _____
Street City State Zip code

Employment Information

The following is for ☐The patient ☐The person responsible for payment

Employer name: _____ **Occupation:**_____

Address: _____
Street City State Zip code

Insurance Information

Name of insured: _____ **Is insured a patient? ☐Yes ☐No**
First, Last, Middle

Relationship to patient: ☐Self ☐Spouse ☐Child ☐Other Insurance Name: _____

Insurance ID #:_____ **Group #:**_____ **Insurance Phone #:** _____

Insurance Address: _____
Street City State Zip code

Consent for Services

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Aesthetic Smile Specialists will assist in preparing insurance claims and follow up with any insurance requests. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any emergency dental services rendered are payable in full on the day of service, All personal checks returned will carry a "Returned Check Fee" of $25.00. Any outstanding account balances over 30days after services rendered, are deemed "*delinquent*" and are subject to *Collections,* which will incur collection fees not to exceed 40% of the account balance.
The Patient will agree to pay any and all legal costs incurred in any legal action brought by the Patient against Aesthetic Smile Specialists, its employees, staff, directors, officers, shareholders or affiliates, in the event Aesthetic Smile Specialists prevails in its defense. The Patient will pay costs incurred in the collection of any delinquent charges, including, but not limited to, collection fees, interest and reasonable attorney fees. The patient agrees to provide the Office with current, accurate and truthful information and agrees to abide by the medical advice including, but not limited to, making and keeping scheduled appointments as directed by her care provider. Patient agrees to provide the office with a valid, working telephone number and a current address at all times.

Consent for Treatment

I hereby authorize my doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.
Upon such diagnosis, I authorize the 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 fully understand that I can ask for a complete recital of any possible complications.
I give consent to the doctor's or designated staff to use and disclose any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protections of my personal health information is available.
I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time service unless other financial arrangements or agreements have been made. In the event that payments are not received by agreed upon dates, I understand that a 1 ½ late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.

I have read the above conditions for treatment and services, and agree to their consent.

Signature of patient/ Parent or guardian

_____ **Date:** _____ **Relationship:** _____