La Jolla Dental Office

Comprehensive Dentistry

Jennifer D. Rens, DDS
J. Daniel Gibson, DDS

Patient Information and Health History

Patient name: (Dr. Mr. Mrs. Ms.) _____ Preferred name: _____

Date of birth: _____ Sex: _____ Age: _____ Driver's License #: _____ State: __

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

SS #: _____ Employer/Occupation: _____ Bus. phone: _____

Spouse's name: _____ Emergency contact: _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Subscriber's date of birth: _____

Name of previous dentist: _____ Date of last dental visit: _____

How did you hear of our office? _____

Dental Health History

	Yes	No
Are you nervous about dental treatment	☐	☐
Any problems with previous treatment	☐	☐
Are your teeth sensitive	☐	☐
Family history of gum disease	☐	☐
Are you happy with your smile	☐	☐
Do you wish your teeth were whiter	☐	☐

	Yes	No
Do you have earaches/pain near the ears	☐	☐
Do your jaws ever feel tired	☐	☐
Does it hurt to chew or open wide	☐	☐
Do you have difficulty chewing food	☐	☐
Do you chew only on one side	☐	☐
Are you aware of an uncomfortable bite	☐	☐

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Medical Health History

Name and contact of your medical doctor: _____

Date of last medical visit: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes: _____

Do you use tobacco? ☐ Yes ☐ No If yes: _____

Do you use controlled substances? ☐ Yes ☐ No If yes: _____

Are you on a special diet? ☐ Yes ☐ No If yes: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes: _____

Have you ever taken Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors, or Zometa for osteoporosis or for any other reason? ☐ Yes ☐ No If yes: _____

Please list all medications and supplements you are currently taking: _____

_____

_____

Are you currently taking blood thinners such as Aspirin, Coumadin, Plavix, Pradaxa, or others? ☐ Yes ☐ No

If so, what is your most recent INR: _____

Allergies
Are you allergic to any medication or substance (Latex, Penicillin, metals, etc)? ☐ Yes ☐ No
If so, please list all allergies: _____
_____

Women	Yes	No
Are you taking birth control _____	☐	☐
Are you pregnant _____	☐	☐
Are you nursing _____	☐	☐
Post-menopausal _____	☐	☐

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

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

Please list any other medical conditions or comments we should be aware of: _____

_____

_____

Signature: _____ Date: _____

*Items in **bold** are associated with inflammation and gum disease

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Consent and Credit Policy

The undersigned hereby authorizes Doctor(s) to take necessary radiographs, study models, photographs, or any other diagnostic aid deemed appropriate by Doctor(s) to make a thorough diagnosis of the patient's dental needs. The best dental care can be provided only on the basis of mutual understanding. Therefore, we encourage you to discuss any questions you may have regarding treatment or our policies.

All charges are due and payable at the time of your visit. You are personally responsible to our office for payment of your account unless previous arrangements have been approved. As a free service, we will bill your insurance at the time the work is done. We require payment while your dental claim is being processed.

Furthermore, this office is authorized to investigate your credit standing by means of a credit report if and when credit is to be extended to our office. A service charge of 1.6% per month (19.2% per year) will be charged on any balance over thirty days. Legal expenses required to collect delinquent accounts will be at the expense of the responsible party.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I have received a copy of the La Jolla Dental Office Notice of Privacy Practices.

Please Print Name: _____

Signature: _____ Date: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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Financial Arrangements

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

___ Payment by cash
___ Payment by check
___ Payment by credit card
___ Third party financing options including CareCredit

Please make your choice, sign below, and return to the office manager before treatment.

If none of the above applies, please see the doctor or office manager to develop a plan based on your dental needs. Thank you.

Signature: _____ Date: _____