Grover Beach Dental
1558 W. Grand Ave
Grover Beach, CA 93433

(805) 489-8904

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # ( ) _____ Cell Phone #1 ( ) _____ Cell Phone #2 ( ) _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collecting between the teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepititis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ None
- ☐ Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

GENERAL CONSENT

1. WORK TO BE DONE
   I understand that I am having the following work done: x-rays (1) Initial ____

2. DRUGS AND MEDICATIONS
   I understand that antibiotics and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.
   (2) Initial ____

3. CHANGES IN TREATMENT
   I understand it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary for the success of my treatment.
   (3) Initial ____

4. REMOVAL OF TEETH
   Alternatives to removal of my teeth (Root Canal Therapy, Crowns and Periodontal Surgery, etc.), have been explained to me, and I authorize the dentist to remove the following teeth, _____ as well as others necessary for reasons explained to me. I understand that removing teeth does not always completely remove the infection, if present. I also understand it may be necessary to have further treatment. I understand the risks involved in having teeth removed, including but not limited to: pain, swelling, spread of infection, dry socket, fractured jaw, and the loss of feeling in my teeth, tongue and surrounding tissue (paresthesia) which can last for an indefinite period of time. I understand that I may need further treatment by a specialist if complications arise during or following treatment; the cost of which is my responsibility. (4) Initial ____

5. TEMPORMANDIBULAR JOINT (TMJ)
   I have been informed that my bite is not correct and failure to have my bite properly rehabilitated before any dental procedure might be the cause of possible pain or damage to the teeth, jaw joint, or muscles of the head and neck. (5) Initial ____

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment of Receipt
(*Patient may refuse to sign this agreement*)

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning his or her personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgment:
You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your Rights and you may choose at some pint in the future to provide more specific instructions for us to follow regarding your personal health.

I have received a copy of this office's Notice of Privacy Practices:

_____ _____ _____
Signature *Date* *Print Your Name*

_____ _____
Signature of Doctor Signature of Witness

PATIENT RESPONSIBILITY

Dear Patient:

You will receive services today with the understanding that in the event your coverage is not effective or benefits are alter, you will be billed and held financially responsible for the services rendered.

_____ _____

Patients Name *Subscriber's Name*

I understand that dentistry is not an exact science and that reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the success of dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.

I hereby authorize any dentist or dental auxiliaries of Grover Beach Family Dentistry, to proceed with and perform the dental treatments and restoration as explained to me. I understand that this is only an estimate subject to modification due to unforeseen or undiagnosable circumstances that may arise during treatment. I understand that regardless of any dental insurance I may have, I am responsible for all payments of dental fees. If the patient or responsible party defaults in payment, Grover Beach Family Dentistry, may exercise all rights and remedies allowed by law, including the right to hold the patient liable for damages which are, the unpaid balance, collection fees, and possible attorney fees.

I have read the above and understand my possible financial responsibility to Grover Beach Family Dentistry and hereby affix my signature as an acknowledgement ot this understanding.

_____ _____

Patient/Guardian Signature *Date*