SANTA MONICA
ESTHETIC DENTISTRY
Where Artistry Meets Clinical Excellence

DENTAL HISTORY

Santa Monica Esthetic Dentistry
1418 7th Street
Suite #101
Santa Monica, CA 90401

tel: 310.458.4000
fax: 310.458.4003

frontoffice@santamonicaedentistry.com
www.santamonicaedentistry.com

Name _____ Nickname _____

Age _____ Referred by _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous dentist _____

How long have you been a patient? _____ Most recent dental exam ____/____/____ Most recent x-rays ____/____/____

Most recent treatment ____/____/____ I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 *(least)* to 10 *(most)* [_____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontics treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? *(pain, sounds, limited opening, locking, popping)* _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes *(i.e. pitting, craters)* on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling _____ ☐ ☐
27. Do you frequently get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own *(without an injury)*, or do you have difficulty eating an apple? ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date: ____/____/____

Doctor's Signature _____ Date: ____/____/____

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MEDICAL HISTORY

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Name _____

Nickname _____ Age _____

Name of Physician _____

Date of recent physical examination ____ / ____ / ____

Purpose _____

What is your estimate of your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	**YES**	**NO**
Hospitalization for illness or injury _____	☐	☐

An allergic reaction to:

☐ Aspirin	☐ Erythromycin	☐ Latex
☐ Ibuprofen	☐ Tetracycline	☐ Metals *(nickel, gold, silver)*
☐ Acetaminophen	☐ Sulfa	
☐ Codeine	☐ Local anesthetic	☐ Other _____
☐ Penicillin	☐ Fluoride	

Heart problems, or cardiac stent within the last six months	☐	☐
History of infection endocarditis _____	☐	☐
Artificial heart valve, repaired heart defect *(PFO)* _____	☐	☐
Pacemaker or implantable defibrillator _____	☐	☐
Artificial prosthesis *(heart valve or joints)* _____	☐	☐
Rheumatic or scarlet fever _____	☐	☐
High or low blood pressure _____	☐	☐
A stroke *(taking blood thinners)* _____	☐	☐
Anemia or other blood disorder _____	☐	☐
Prolonged bleeding due to a slight cut *(INR > 3.5)* _____	☐	☐
Emphysema, sarcoidosis _____	☐	☐
Tuberculosis _____	☐	☐
Asthma _____	☐	☐
Breathing or sleep problems *(i.e. snoring, sinus)* _____	☐	☐
Kidney disease _____	☐	☐
Liver disease _____	☐	☐
Jaundice _____	☐	☐
Thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
Hormone deficiency _____	☐	☐
High cholesterol or taking statin drugs _____	☐	☐
Diabetes *(HBA1C =)* _____	☐	☐
Stomach or duodenal ulcer _____	☐	☐
Digestive disorders *(i.e. gastric reflux)* _____	☐	☐
Osteoporosis / osteopenia *(i.e. taking bisphosphonates)* _____	☐	☐
Arthritis _____	☐	☐
Glaucoma _____	☐	☐
Contact lenses _____	☐	☐
Head or neck injuries _____	☐	☐
Epilepsy, convulsions *(seizures)* _____	☐	☐
Neurologic problems *(attention deficit disorder)* _____	☐	☐
Viral infections and cold sores _____	☐	☐
Any lumps or swelling in the mouth _____	☐	☐
Hives, skin rash, hay fever _____	☐	☐
Venereal disease _____	☐	☐
Hepatitis *(type)* _____	☐	☐
HIV / AIDS _____	☐	☐
Tumor, abnormal growth _____	☐	☐
Radiation therapy _____	☐	☐
Chemotherapy _____	☐	☐
Emotional problems _____	☐	☐
Psychiatric treatment _____	☐	☐
Antidepressant medication _____	☐	☐
Alcohol / street drug use _____	☐	☐
Presently being treated for any other illness _____	☐	☐
Aware of a change in your health *(i.e. fever, new cough)* _____	☐	☐
Taking medication for weight management *(i.e. fen-phen)* _____	☐	☐
Taking dietary supplements _____	☐	☐
Often exhausted or fatigued _____	☐	☐
Experiencing frequent headaches _____	☐	☐
A smoker, smoked previously or use smokeless tobacco _____	☐	☐
Considered a touchy person _____	☐	☐
Often unhappy or depressed _____	☐	☐
FEMALE - taking birth control pills _____	☐	☐
FEMALE - pregnant _____	☐	☐
MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. *(i.e. Botox, Collagen injections)*

_____

PLEASE LIST ALL MEDICATIONS SUPPLEMENTS AND / OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS
(Ask for an additional sheet if you are taking more than 6 medications)

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU ARE TAKING

Patient's Signature _____ Date: ____ / ____ / ____

Doctor's Signature _____ Date: ____ / ____ / ____

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PATIENT INFORMATION

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PLEASE TAKE A MOMENT TO ENTER OR UPDATE YOUR INFORMATION TO HELP US ENSURE THE QUALITY OF YOUR CARE IS EXCELLENT.

Chart # _____
FOR OFFICIAL USE ONLY

Name _____ Nickname _____

Title *(Mr. / Ms. / Mrs. / etc.)* _____ ☐ Male ☐ Female Family Status ☐ Married ☐ Single ☐ Child ☐ Other

Birth date ____ / ____ / ____ Previous visit ____ / ____ / ____ Email address _____

Home phone _____ Work phone _____ Ext _____ Cell _____

Best time to reach you _____ Preferred location ☐ Home ☐ Work ☐ Cell

Address _____

City _____ State _____ Zip _____

Preferred appointment days ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thu. ☐ Fri. Preferred appointment time ☐ Morning ☐ Afternoon

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Newspaper ☐ Yellow Pages ☐ Internet ☐ School ☐ Work ☐ Other *(Name below)*

Name of person, office, or other source referring you to our practice _____

If you are unable to keep your appointment, kindly give 48 business hour notice to avoid a $100 per hour missed appointment fee.

Thank you for your consideration.

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SPOUSE OR RESPONSIBLE PARTY INFORMATION

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The following is for: ☐ The patient's spouse ☐ The person responsible for payment ☐ Neither-not applicable

Name _____ Nickname _____

Title (Mr. / Ms. / Mrs. / etc.) _____ ☐ Male ☐ Female Family Status ☐ Married ☐ Single ☐ Child ☐ Other

Birth date ____ / ____ / ____ Previous visit ____ / ____ / ____ Email address _____

Home phone _____ Work phone _____ Ext _____ Cell _____

Best time to reach you _____ Preferred location ☐ Home ☐ Work ☐ Cell

Address _____

City _____ State _____ Zip _____

EMPLOYMENT INFORMATION

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

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

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PRIMARY INSURANCE INFORMATION

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Name of Insured _____

Birth date ____ / ____ / ____ ID # _____ Group # _____

Address _____

City _____ State _____ Zip _____

Insured's Employer Name _____ State _____ Zip _____

Employer Address _____

City _____ State _____ Zip _____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name _____

Insurance Address _____

City _____ State _____ Zip _____

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Thank you for your consideration.

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CONSENT FOR SERVICES

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As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed unless other arrangements are made.

This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance. The patient is responsible for any claims or balances that are not covered by their insurance unless other written arrangements have been made.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of 60 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charged for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or you assignee, to telephone me to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment / responsible party

Signature _____ Date: ____ / ____ / ____

Relationship to patient _____

Response date ____ / ____ / ____

If you are unable to keep your appointment, kindly give 48 business hour notice to avoid a $100 per hour missed appointment fee.

Thank you for your consideration.

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TRUTH - IN - LENDING STATEMENT

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As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services preformed without previous financial arrangements must be paid for in cash and at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to my by this practice, I agree to pay the charges for the services a the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charged for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time of condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or you assignee, to telephone my to discuss matters related to this form.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment / responsible party

Signature _____ Date: _____ / _____ / _____

Relationship to patient _____

Response date _____ / _____ / _____

If you are unable to keep your appointment, kindly give 48 business hour notice to avoid a $100 per hour missed appointment fee.

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EPWORTH SLEEPINESS SCALE

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RATE THE CHANCE THAT YOU WOULD DOZE OFF DURING THE FOLLOWING 8 ROUTINE DAYTIME SITUATIONS.

0 = Would never dose
1 = Slight chance of dozing
3 = Moderate chance of dozing
4 = High chance of dozing

_____ Sitting and reading

_____ Watching television

_____ Sitting inactive in a public place

_____ Lying down to rest in the afternoon

_____ Sitting and talking to someone

_____ Sitting quietly after a lunch without alcohol

_____ In a car, while stopped for a few minutes in traffic

_____ As a passenger in a car for an hour without a break

SCORING THE QUESTIONNAIRE

Scoring 1 - 6 = Getting enough sleep

Scoring 7 - 8 = You are average

Scoring 9+ = You need to seek advice of a sleep specialist.