Warner Center
COSMETIC DENTAL

Reset form

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT NAME: _____ (FIRST) _____ (LAST) ____ (MI) _____ (Preferred name)

GENDER: ◯ Male ◯ Female **STATUS:** ◯ single ◯ married ◯ child ◯ other

SPOUSE'S NAME: _____

DATE OF BIRTH: _____ /_____ /_____ (month day year) **Age:**_____ **SS#:** _____--_____--_____

Driver's License#: _____

HOME ADDRESS: _____ **APT. #:** _____

CITY: _____ **STATE:**_____ **ZIP:** _____

HOME #: (____) _____ **WORK #:** (____) _____ Ext. _____.

CELL #: (____) _____. **E-MAIL ADDRESS:** _____

We provide all our patients with e-mail and text message appointment reminders. If you wish NOT to receive any of these services please check the box/s below *(your e-mail address as well as other personal information is for office use only and will not be shared with third parties.)*:

☐ Please DO NOT text message me. ☐ Please DO NOT e-mail me.

EMPLOYER: _____ **How long have you been employed with this company?** _____

EMPLOYER'S ADDRESS: _____ **CITY:** _____

STATE:_____ **ZIP:** _____ **OCCUPATION:** _____

HOW DID YOU LEARN ABOUT OUR DENTAL OFFICE? *(Please check one of the boxes below)*

☐ Internet Search ☐ Advertising ☐ Directories ☐ Word of mouth

☐ Friend (*Name*:_____) ☐ Relative: (*Name*:_____, *relation*:_____)

EMERGENCY CONTACT

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

HOME #: (____) _____ **WORK #:** (____) _____ Ext. _____.

CELL #: (____) _____. **OTHER #:** (____) _____.

YOUR MEDICAL DOCTOR: _____ **DOCTOR'S PHONE #:** (____) _____.

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(If you do not have dental insurance coverage, please skip to next section, pg. 3)

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

COMPANY NAME: _____ **PHONE #:** (____) _____.

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURED'S SS#: _____--_____--_____ **GROUP # (Plan, Local or Policy#):** _____

INSURED'S NAME: _____ **RELATIONSHIP:** _____ **D.O.B:** ___/___/_____

INSURED'S EMPLOYER: _____

SECONDARY DENTAL INSURANCE

COMPANY NAME: _____ **PHONE #:** (____) _____.

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURED'S SS#: _____--_____--_____ **GROUP # (Plan, Local or Policy#):** _____

INSURED'S NAME: _____ **RELATIONSHIP:** _____ **D.O.B :** ___/___/_____

INSURED'S EMPLOYER: _____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL INSURANCE POLICES

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided

- I certify that I or my child is covered by insurance and assign directly to Dr. Robert M. Solow all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the dentist to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Patient Signature: _____ **Date:** _____
(Signature of legal Guardian or Parent if Patient is under 18 years of age)

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YOUR DENTAL INFORMATION

REASON FOR TODAY'S VISIT: ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION

Are you in pain? ○ NO ○ YES
If YES, please rate your pain from 1-10:____ **How long has this pain persisted?** _____

Do you feel nervous about having dental treatment? ○ NO ○ YES

If YES, explain:_____

Have you had problems with prior dental treatment or an upsetting dental experience? ○ NO ○ YES

If YES, explain:_____

Name of previous dentist:_____

Date of last dental exam?:_____**Date of last dental X-rays?:** _____

Are you interested in learning more about the following?: ***(check all that apply)***

☐ **Teeth Whitening**	☐ **Tooth-colored filings**	☐ **At-home oral hygiene care**
☐ **Orthodontic treatment**	☐ **Dental implants**	☐ **Periodontal treatment during pregnancy**
☐ **Veneers**	☐ **How to prevent periodontal disease**	☐ **Oral hygiene care for infants & toddlers**

ACCOUNT INFORMATION & AUTHORIZATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

NAME: _____ _____ **RELATIONSHIP:** _____
(FIRST) (LAST)

BILLING ADDRESS:_____ **SUITE / APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE #: (____)_____ **E-MAIL ADDRESS:** _____

CONFIDENTIAL HEALTH HISTORY

MEDICAL HISTORY **Please check and/or fill in the appropriate answer**.

1. **Please rate your general health from 1 to 10:**_____
2. ○**Yes** / ○**No** **Has there been a change in your health within the last year?**
   If YES, explain: _____
3. ○**Yes** / ○**No** **Are you being treated by a physician now for a current medical condition?**
   If YES, explain: _____
   Date of last medical exam?_____**Reason for exam:** _____

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SYMPTOMS **Have you experienced any of the following in the last 3 months? (Please check all that apply)**

- ☐ Chest pain (angina)
- ☐ Fainting spells
- ☐ Unexplained weight loss
- ☐ Fever
- ☐ Night sweats
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Diarrhea
- ☐ constipation
- ☐ Frequent urination
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Dizziness
- ☐ Bruise easily
- ☐ Frequent vomiting
- ☐ Jaundice
- ☐ Dry mouth
- ☐ Excessive thirst
- ☐ Difficulty swallowing
- ☐ Swollen neck glands
- ☐ Swollen ankles
- ☐ Joint pain, stiffness
- ☐ Sinus problems

CONDITIONS **Have you had or do you have any of the following?** *(Please check all that apply)*

- ☐ Artificial joints (Type_____Year_____)
- ☐ Heart disease
- ☐ Family history of heart disease
- ☐ Heart attack
- ☐ Heart defects
- ☐ Heart murmurs
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Cosmetic surgery
- ☐ Surgeries
- ☐ Ulcers
- ☐ Diabetes
- ☐ Family history of diabetes
- ☐ Tumors Cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Arthritis, rheumatism
- ☐ Emphysema or other lung disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Kidney or bladder disease
- ☐ Eating disorders
- ☐ Osteoporosis
- ☐ Thyroid disease
- ☐ Hepatitis (Type_____)
- ☐ Sexual transmitted disease
- ☐ Herpes
- ☐ Canker or cold sores
- ☐ Anemia
- ☐ Liver disease
- ☐ Glaucoma
- ☐ Transplant

CONDITIONS CONTINUED… **This information will not be released unless specifically authorized by patient.**
(Please check all that apply)

- ☐ HIV
- ☐ Anxiety
- ☐ Treatments for emotional condition
- ☐ Depression

ALLERGIES **Are you allergic to or have you had a reaction to any of the following?**
(Please check all that apply)

- ☐ Aspirin
- ☐ Darvon
- ☐ Valium
- ☐ Demerol
- ☐ Codeine
- ☐ Vicodin
- ☐ Percodan
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Food (type_____)
- ☐ Nitrous Oxide
- ☐ Metal
- ☐ Novocain or Xylocaine
- ☐ Latex
- ☐ Iodine
- ☐ Acrylic

Please list any other medications or substances you are or may be allergic to: _____

_____

Name: _____

6325 Topanga Canyon Blvd, Ste 515
Woodland Hills, California 91367
818 - 999 - 0104

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MEDICATIONS / SUBSTANCES **Are you taking or have you taken any of the following in the last 3 months?** *(Please check all that apply)*

☐ Antibiotics	☐ Supplements	☐ Recreational drugs.
☐ Over-the-counter medicines	☐ Aspirin Daily	☐ Tobacco in any form
☐ Weight loss medications	☐ Blood Thinners (Coumadin)	☐ Alcohol
☐ Corticosteroids	☐ Bisphosphonate (Fosamax)	

Please list all medications you are currently taking: _____

WOMEN ONLY *(Please check all that apply)*

○ Yes / ○ No **Are you taking birth control pills?**
○ Yes / ○ No **Are you or could you be pregnant? If YES, what month?** _____
○ Yes / ○ No **Are you nursing?**

ALL PATIENTS *(Please check all that apply)*

○ Yes / ○ No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**

If YES, explain: _____

○ Yes / ○ No **Have you ever been pre-medicated for dental treatment? If YES, why:** _____

○ Yes / ○ No **Have you ever taken Pondimin or Fen-Phen? If YES, when:** _____

○ Yes / ○ No **Are you a smoker? If YES, how much do you smoke per day? How long have you smoked?** _____

ALL PATIENTS - SLEEP ASSESSMENT *(Please check all that apply)*

○ Yes / ○ No **Have you ever been told you stop breathing while asleep?**

○ Yes / ○ No **Have you ever fallen asleep or nodded off while driving?**

○ Yes / ○ No **Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?**

○ Yes / ○ No **Do you feel excessively sleepy during the day?**

○ Yes / ○ No **Do you snore, or have you ever been told that you snore?**

○ Yes / ○ No **Have you had weight gain and found it difficult to lose?**

○ Yes / ○ No **Have you taken medication for, or been diagnosed with high blood pressure?**

○ Yes / ○ No **Do you kick or jerk your legs while sleeping?**

○ Yes / ○ No **Do you feel burning, tingling or crawling sensations in your legs when you wake up?**

○ Yes / ○ No **Do you wake up with headaches during the night or in the morning?**

○ Yes / ○ No **Do you have trouble falling asleep?**

○ Yes / ○ No **Do you have trouble staying asleep once you fall asleep?**

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The practice of dentistry involves treating the whole person. If Dr. Solow determines that there may be a medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Do you authorize Dr. Solow and/or his staff to contact your physician if necessary? ◯YES ◯NO

Physician's Name:_____ **Office phone #:**_____

ROBERT M. SOLOW, D.D.S, INC. – DENTAL PRACTICE POLICES

- We invite you to discuss with us any questions regarding our services. We are best able to address your dental needs, desires and concerns when there are open communications to assure mutual understanding between you and our staff.
- The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the dental staff to perform necessary dental services for me/ my minor/child.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. In the absence of a preexisting financial arrangement, if your account is greater than 90 days past due, you may be held liable for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your account.
- In an effort to improve patient scheduling and care, we respectfully request that you advise us of your need to cancel or change your appointment at least ***24 hours*** prior to your reserved time. Please extend this courtesy both to us and to other patients who may benefit from your appointment time. If you find it necessary to change or cancel an appointment at the last minute, there will be a charge of ***$45.00*** for each hour of appointed time. While we understand that unforeseen emergencies and illness may occur, we ask that you consider the value of our time and the needs of other patients.
- I certify that I have read and understand the above statements of Office Policy and Health History which I completed. I have answered each question accurately and to the best of my knowledge. I will continue to inform this office and staff of any change in my health status and/or medication. I also consent to Dr. Solow's office using my cell phone to contact me regarding any appointments, insurance information or account matters. Further, I will not hold Dr. Solow, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

(Signature of legal Guardian or Parent if Patient is under 18 years of age)

MEDICAL UPDATES (*Office use only*)

Date	Changes to Health History	Dentist or Hygienist Initials

Submit via Email

You can save and email this form or print and bring it with you to the office.