Corporate Pointe Dental

100 Corporate Pointe, Suite 170
Culver City, CA 90230

Thank you for selecting our dental office. We will strive to provide you with the best possible care. To help us meet all your dental goals, please complete these forms.

Patient Information (CONFIDENTIAL)

Date ____________

Name ____________ Birthday ____________ Soc. Sec # ____________

Address ____________ City ____________ State ________ Zip ________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

What is the best number to reach you at? ____________ What Time ____________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation ____________ Spouse Name ____________ Any Children? ____________

If Full time Student, Name of School/ College ____________ City____________ State ______

Whom May We Thank for Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Please provide your e-mail address: ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship ____________

Address ____________ City ____________ State ________ Zip ________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Dental Insurance Information

Will some of your dental work be covered by insurance? ☐ **Yes** ☐ **No**

Name of Insured ____________ Relationship ____________

Birthdate ____________ Social Security # ____________ Work Phone ____________

Name of Employer ____________ Union or Local # ____________

Insurance Company ____________ Group # ____________

Ins Co Address ____________ City ____________ State ______

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE ? ☐ **Yes** ☐ **No** IF YES, COMPLETE THE FOLLOWING...

Name of Insured ____________ Relationship ____________

Birth date ____________ Social Security # ____________ Work Phone ____________

Name of Employer ____________ Union or Local # ____________

Insurance Company ____________ Group # ____________

Ins Co Address ____________ City ____________ State ______

CORPORATE POINTE DENTAL

APPOINTMENTS
So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept a definite arrangement for appointments. Once an appointment is made, please remember this time is reserved for you. AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE A **$50 CHARGE FOR THE BROKEN APPOINTMENT WILL BE MADE.**

HYGIENE APPOINTMENTS
Our hygienists are extremely professional and highly paid. They are paid whether they are with a patient or not. **BROKEN APPOINTMENT CHARGE** will be applied when less than **24 hour notice** is given for rescheduling hygiene appointments.

INSURANCE
To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. **WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT THE INSURANCE COMPANIES WILL PAY ALL OUR FEES**.

RETURNED CHECKS
There is a **$50** charge for ALL CHECKS RETURNED to our office from the bank for any reason.

PROFESSIONAL FEES
Professional fees are to be paid when services are rendered unless previous financial arrangements have been made.

If you are completing this registration for another person, what is the relationship?

____

____

____

____

____

Signature of patient/responsible party   Dentist   Date

Dental History (CONFIDENTIAL)

Correct answers to the following questions will allow our office to treat you on a more individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Do you visit the dentist regularly? ☐ **Yes** ☐ **No**

Date of last dental: Visit ______________ Exam ________________ X-rays of all of your teeth ________________

How often do you brush? _________________ Do you avoid brushing any part of your mouth? __________________

Do you brush your teeth ☐ vigorously ☐ lightly My brush is: ☐ Soft ☐ Medium ☐ Hard

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

What can we do to make you more comfortable? ____

Have you ever been treated for periodontal disease? (Gum disease, pyorrhea, trench mouth) ☐ **Yes** ☐ **No**

Do you have any of the following:

MOUTH	**Yes**	**No**	TEETH	**Yes**	**No**
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breathe	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blister, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Biting cheeks/lips	☐	☐	Food Impaction	☐	☐

Do you have any missing teeth? ☐ **Yes** ☐ **No** If so, how long have they been missing? __________________

____

Why didn't you have them replaced? ____________________________________ Was it ever suggested? ______

____

Have you ever had braces? ☐ **Yes** ☐ **No** If yes, what calendar years? __________________________

Do you chew on both sides of your mouth? ☐ **Yes** ☐ No If no, please explain __________________________

Do you have a tired feeling in your face while chewing or at the end of the day after considerable talking? ☐ **Yes** ☐ **No**

Have you ever had a reaction to a dental anesthetic or any problems with dental work? ☐ Yes ☐ **No** If yes, please explain ____

Are you aware of your jaw clicking or popping while you are eating or yawning? ☐ **Yes** ☐ **No** How often? _______

Do you have headaches, chronic neck or shoulder pain? ☐ **Yes** ☐ **No** If yes, where? __________________

Do you clench or grind your teeth? ☐ **Yes** ☐ **No** Has anyone made you aware that you do this? ________________

Do you know that decay and gum disease can occur without your being aware of it? ☐ **Yes** ☐ **No**

Are you having any discomfort at this time? ☐ **Yes** ☐ **No** If yes, please explain ___________________________

____

Is there anything else you would like us to know? ____

____

Patient Signature ____ **Date** __________________

Health History (CONFIDENTIAL)

Have there been any problems in your general health within the past 5 years? (Serious illness, hospitalization, surgery, etc.)

☐ **Yes** ☐ **No** If yes, please explain ____________________

Have you had any form of Cancer? ☐ **Yes** ☐ **No** If so what type? ____________________

Date of last medical check up ____________________ Attending Physician ____________________

Date of last blood test ____________________ Attending Physician ____________________

Are you currently under a physician care now? ☐ **Yes** ☐ **No** If yes, please explain ____________________

____

Please list any medications you are currently taking (vitamins, drugs, pain pills, herbs, etc.) ____________________

____

Are you required to take any medication before having dental work done? ☐ **Yes** ☐ **No** If yes, what? ____________________

Have you had a positive test for the aids virus (HIV+)? ☐ **Yes** ☐ **No** What date? ____________________

Physician's name ____________________ Phone # ____________________

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

Yes	No		Yes	No	
☐	☐	Rheumatic fever, Rheumatic heart disease	☐	☐	Heart Murmur, Mitral valve prolapse
☐	☐	Eating disorder	☐	☐	Heart trouble, Heart attack
☐	☐	Pain in chest, Shortness of breathe	☐	☐	High Blood Pressure, Stroke
☐	☐	Blood disorder, Anemia	☐	☐	Diabetes
☐	☐	Positive test for venereal disease	☐	☐	Asthma or Hay Fever
☐	☐	Cold sores, Herpes incident	☐	☐	Low blood pressure
☐	☐	Kidney trouble	☐	☐	Bruise easily, Abnormal bleeding
☐	☐	Radiation treatment	☐	☐	Fainting Spells, Seizures
☐	☐	Hepatitis A, B or C	☐	☐	Jaundice, Liver disease
☐	☐	Arthritis	☐	☐	Persistent cough
☐	☐	Sores that do not heal in 1week	☐	☐	Artificial joint replacement
☐	☐	Organ transplant	☐	☐	Swollen ankles
☐	☐	Back trouble or surgery	☐	☐	Whiplash injury
☐	☐	Tuberculosis	☐	☐	Do you smoke _____ pk per _______
☐	☐	Alcoholism	☐	☐	Drug addiction

FOR WOMEN ONLY

☐	☐	Are you pregnant? Due Date____________	☐	☐	Taking birth control pills?

Do you have any disease, condition or problem not listed above that we should know about? ____________________

____

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No	
☐	☐	Penicillin	☐	☐	Erythromycin	☐	☐	Codeine
☐	☐	Aspirin	☐	☐	Pain Pills	☐	☐	Metals
☐	☐	Latex	☐	☐	Vinyl	☐	☐	Sulfa
☐	☐	Tylenol	☐	☐	Ibuprofen	☐	☐	Acrylic

Anything not listed above ____________________

Patient Signature ____________________ **Date** ____________________