Phone: 323.686.6522
Fax: 323.290.4072

5010 S. La Brea Ave
Los Angeles, CA 90056

lasmilesdentistry.com

We would like to get to know you better!

Date_____

Name_____ ☐ **Male** ☐ **Female**

Address_____**City**_____**State**_____**Zip**_____

Home Phone_____ **Work Phone**_____ **Cell phone**_____

E-mail Address_____ **Date of Birth**_____

Occupation_____ **Employer**_____

Parent or Spouse's Name _____**Their Work Phone**_____

Whom may we thank for referring you? _____

Person to Contact in case of emergency _____**Phone**_____

Person responsible for dental investment _____

Dependents that are covered under parents Insurance and over the age of 18 we need a copy of Student Status for Insurance purpose.

Student Status: Full Time Total Semester Hr's_____ **Part Time Total Semester Hr's**_____

For Insurance Purposes:

Name of policy holder_____ **Date of Birth**_____ **Relationship to Patient:** _____

SS# _____**Member I.D.** _____ **Employer** _____

Insurance Company _____

Ins. Company Number _____**Group Number**_____

HIPPA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients in an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards, and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs in regards to privacy issues, please put them in writing for the office so that we may address your concerns.

Financial Information:

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or his staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that the payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment in made.

Patient Signature: _____Date: _____

Dentist/Hygienist Signature:_____Date: _____

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Patient Name: _____

Medical History

Please circle (Y) for "yes" or (N) for "no" for any of the following which may apply to you now or in the past:

Y N Heart attack or Heart Trouble
Y N Congenital Heart Disease
Y N Chest pain with exercise (angina)
Y N High Blood Pressure
Y N Heart Valve disorder
Y N Pacemaker
Y N Implants or Artificial Joint When?_____
Y N Anemia or blood disorder
Y N Excessive bleeding
Y N Diabetes
Y N Stroke
Y N Thyroid disease
Y N Asthma

Y N Ulcers, Reflux, or Heartburn
Y N Digestive disorders
Y N Kidney problems
Y N Fainting or Blackouts
Y N Headaches or Migraines
Y N Epilepsy or Seizures
Y N Tumors, Cancer, radiation treatment
Y N Tuberculosis, lung problems
Y N Hepatitis A B C D
Y N AIDS or HIV infections
Y N Psychiatric Disorders
Y N Use tobacco? How much? _____
Y N Drug/Alcohol dependency

Is there any family history of the following?

Y N Heart Disease
Y N Early Term Birth
Y N Stroke
Y N Cancer

Are you currently pregnant? _____If yes when are you expecting: _____
Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N
If yes, please explain _____
Physician's name and phone: _____
Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, aspirin, latex, or metals?
If yes, please explain _____
What prescription or over the counter drugs, medications, vitamins, or herbs are you taking at this time?

_____ _____
_____ _____
_____ _____

Dental History

Y N Are you experiencing any dental discomfort?
Y N Is your mouth frequently dry?
Y N Does your jaw become sore with chewing?
Y N Do you ever experience hot/cold/sweet/pressure
Y N Do you grind your teeth?

How often do you brush your teeth?_____ How often do you floss your teeth? _____
On a Scale from 0-10, zero being the *least important* and ten being the *most important,* please rate the following:
Dental Anxiety: _____ Optimizing appearance/function: _____
Your Smile: _____ Prevent future problems: _____
Maintain Current Conditions: _____ Problem Driven:_____
Have you ever had any problems associated with previous dental treatment?_____

_____
_____

Patient Signature: _____Date: _____
Dentist/Hygienist Signature:_____Date: _____