

NEW PATIENT INFORMATION FORM

Welcome to our office!

In order to serve you properly, we need the following information.

All information is strictly confidential. *(Please print clearly)*

Date: _____

GENERAL	Patient's Name: _____ Sex (M/F) _____ Birth date: _____ (First) (Last)
	Address: _____ City: _____ State: _____ Zip: _____
	Home Phone No.: (____) _____ Work Phone No.: (____) _____ Pager No. (____) _____
	Driving License No. _____ Soc. Sec. No.: _____ Referred By: _____
	Email: _____ Occupation: _____ Marital Status: _____
	Person Responsible for the Account – Name: _____ (First) (Last)
	Relationship to Patient: _____ Birth Date: _____ Soc. Sec. No.: _____ (First) (Last)
	Address: _____ City: _____ State: _____ Zip: _____
Home Phone No.: (____) _____ Work Phone No.: (____) _____ Pager No.: (____) _____	

DENTAL HISTORY	Chief Complaint / Reason for Visit: _____
	When Was Your Last Dental Visit? _____ Last Full Mouth X-Ray? _____ Last Teeth cleaning? _____
	DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING? – (PLEASE CHECK ALL THAT APPLY)
	<input type="checkbox"/> Teeth Sensitive to Cold, Heat, Sweet and Pressure <input type="checkbox"/> Clenching or Grinding <input type="checkbox"/> Finger Nail Biting, Cheek Biting <input type="checkbox"/> Bleeding Gums? How Long? _____ <input type="checkbox"/> Pain Around Ear <input type="checkbox"/> Frequency of Brushing _____ <input type="checkbox"/> Food Impaction <input type="checkbox"/> Unusual Sounds in Ear While Eating <input type="checkbox"/> Dental Floss <input type="checkbox"/> Bad Breath <input type="checkbox"/> Orthodontic Treatment <input type="checkbox"/> Water Jet Device <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Periodontal Treatment <input type="checkbox"/> Flouride Supplement <input type="checkbox"/> Cigarettes, Pipe or Cigar Smoking <input type="checkbox"/> Partial or Complete Denture <input type="checkbox"/> Professional Teeth Whitening
	Are You Happy with Your Smile? _____
	Please Add Anything You Feel Is Important: _____

INSURANCE	Do You Have Insurance or Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company Name: _____ Plan: _____
	Name of Insured: _____ Relationship to Patient: _____ Soc. Sec. No. _____
	Do You Have Any Other Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Insurance Company Name: _____ Plan: _____
	I authorize the release of any medical/dental/personal information necessary to process dental claim, and I authorize payment of dental benefit to the Dental Group of Beverly Hills for professional services rendered. <p style="text-align: right;">Signature: _____</p>

I authorize the dental staff to perform any necessary dental service(s) with my informed consent that I may need during diagnosis and treatment. I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. It is customary to pay for services when rendered, unless other arrangements have been made in advance.

I acknowledge that I have received a copy of the "Dental Material Fact Sheet as required by law.

I acknowledge that I have received a copy of the "Notice of Privacy Practices".

Signature: _____

Thank you for choosing our office!