PLAZA DENTAL GROUP
78-461 Hwy. 111 • La Quinta, CA 92253
Tel (760) 564-5455 • Fax (760) 564-3874
www.plazadentalgrp.com

PATIENTS

Name_____ Birth Date/Age _____ Marital Status _____

Parent or Guardian _____

Address_____ City_____ Zip _____

Home Phone _____ Cell _____ Email _____ SS # _____

Employer_____ Occupation _____ Phone _____

Employer Address_____ City_____ Zip _____

Spouse _____ Birth date _____ SS # _____

Employer_____ Occupation _____ Phone _____

Employer Address_____ City_____ Zip _____

Nearest Relative (not living with you) _____ Phone _____

Physician_____ Phone _____

Address_____ City_____ Zip _____

List physicians seen in last five years_____

_____

Who may we thank for recommending us to you? _____

I will be paying today by: Cash _____ Check _____ Credit Card _____

Card Account # _____

DENTAL HISTORY:

Have you ever had any unfavorable reaction from anesthetic? Yes _____ No _____

Do your gums ever bleed when brushing or flossing? Yes _____ No _____

Do you ever have an unpleasant odor or taste in your mouth? Yes _____ No _____

Is any part of your mouth sensitive to temperature changes; pressure, sweet? Yes _____ No _____

If yes, please explain _____

Have you had Dental X-Rays taken within the last six months? Yes _____ No _____

How long has it been since your last Dental Check-up? _____

What are your deepest concerns about restoring your mouth to Dental Health? _____

_____

Fear?_____

Finances? _____

Time? _____

Do you have any objection to X-Rays or Fluoride Treatment? Yes _____ No _____

If yes, please explain _____

Do you have any objection to being contacted at your place of work? Yes _____ No _____

Please add anything you feel is important to help us make your Dental Experience in our office more pleasant _____

HEALTH INFORMATION

Are you presently under the care of a Physician? Yes _____ No _____
If yes, please explain _____

Are you taking Tagamet? Yes _____ No _____

Are you taking antacids regularly? Yes _____ No _____
If so, what? _____

Are you taking herbal supplements? St. John's Wort? Yes _____ No _____
If so, what? _____

Are you taking any medications? Birth control pills or hormones? Yes _____ No _____
If so, what? _____

Are you sensitive or allergic to any medications? Yes _____ No _____
If so, what? _____

Do you have any Heart Condition? Yes _____ No _____

If so, do you require antibiotics before Dental Treatment? Yes _____ No _____

If you smoke, how many packs per day? _____

Are you taking Fosamax, Actonel or Boniva? Y__N__

Please check any of the following conditions that may apply to your health:

Yes ____No ____Anemia	Yes____ No____ Blood Diseases	Yes ____No ____Ulcers
Yes ____No ____High Blood Pressure	Yes____ No____ Hepatitis, Liver Disease	Yes ____No ____Epilepsy
Yes ____No ____Respiratory Disease	Yes____ No____ Kidney Disease	Yes ____No ____Stroke
Yes ____No ____Tuberculosis	Yes____ No____ Tumors/Growths	Yes ____No ____Mental Disorder
Yes ____No ____Nervous Disorder	Yes____ No____ Radiation Treatments	Yes ____No ____Glaucoma (If so, what kind?)
Yes ____No ____Diabetes	Yes____ No____ Asthma/Hay Fever	Yes ____No ____Sinus Pressure
Yes ____No ____Excessive Bleeding	Yes____ No____ Fainting/Seizures	Yes ____No ____Allergies/Latex
Yes ____No ____Rheumatic Fever	Yes____ No____ Head Injuries	Yes ____No ____Aids
Yes ____No ____Sexually Transmitted Diseases	Yes____ No____ Implants	Yes ____No ____HIV

Any chance you may be pregnant or planning pregnancy in the near future? _____

If you are pregnant, how many months are you? _____

Please circle any of the following that may apply to you: Knee, Hip, or other Artificial Joint Implant, Heart Valve Transplant, or Pacemaker.

Please add anything about your health you feel is important

Consent For Treatment: Having been fully advised of necessary treatment, I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment or to administer such anesthetics, analgesics, sedatives or nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

All Services Are Rendered And Accepted Under The Terms And Conditions Below:
As a condition of your treatment by this office, financial arrangements must be made in advance. All costs incurred are the responsibility of the patient, whether or not the patient has dental insurance. Whereas we will be pleased to assist in obtaining the patients' benefits, payment for treatment when rendered is required. Insurance forms will not be accepted in lieu of payment.

A billing charge of $5.00 per month on any balance that exceeds 90 days MAY be charged, and any cost incurred in the attempt to collect outstanding balances through legal recourse will be paid by the patient or responsible party.

Missed appointments, unless cancelled at least 24 hours in advanced, our policy is to charge for missed appointments at the rate of a normal office visit.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY, AND I AGREE TO THIS FINANCIAL POLICY.
I HAVE RECEIVED A COPY OF THE DENTAL MATERIAL FACTS SHEET AS REQUIRED BY LAW.

SIGN _____ DATE _____
(patient or responsible party)