Beverly Hills
PERIODONTAL ARTS & IMPLANTS
We Practice the Science Artfully

Welcome

ABOUT YOU

Patient Info:

Last _____ First _____ MI ____

What do you prefer to be called? _____

Birthday ____/____/____ SS #_____ Sex: ☐ M ☐ F

Whom may we thank for referring you? _____

Address: STREET _____

City _____ State_____ Zip_____

Home Phone #: _____

Work #: _____

Cell #: _____

E-mail Address: _____

When and where is the best time to reach you? _____

Employer: _____

Employer's Address: _____

_____
City State Zip

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated

DENTAL INSURANCE

Primary Dental Insurance:

Ins Company Name _____

Address: STREET _____

City _____ State_____ Zip_____

Ins Co Phone #: _____

Subscriber Name: _____

Relationship to Patient: _____

Birthday ____/____/____ SS #_____ Sex: ☐ M ☐F

Employer: _____ Group #: _____

Secondary Dental Insurance:

Ins Company Name _____

Address: STREET _____

City _____ State_____ Zip_____

Ins Co Phone #: _____

Subscriber Name: _____

Relationship to Patient: _____

Birthday ____/____/____ SS #_____ Sex: ☐ M ☐F

Employer: _____ Group #: _____

RESPONSIBLE PARTY

Person Ultimately Responsible for Account: (If self, please skip)

Name: Last _____ First _____ MI ____

Relationship to patient: _____

Birthday ____/____/____ SS #_____ Sex: ☐ M ☐ F

Address: STREET _____

City _____ State_____ Zip_____

Home Phone #: _____

Work #: _____

Cell #: _____

Employer _____

Occupation _____ Driver License #:_____

EMERGENCY CONTACT

(Please specify someone *not* living with you)

Name:_____Relation_____

Address:STREET:_____

City:_____State:_____Zip:_____

Home #: _____Work#_____

Cell #: _____

DENTAL HISTORY

Dental Info:

Reason for today's visit: _____

_____

Who is your General Dentist? _____

Location (city, state):_____Phone # _____

Date of last: Dental visit: _____ *Dental X-rays:* _____

How often do you: Brush _____ Floss: _____

Please circle any of the following that currently apply to you:

Bleeding gums	Bad breath
Gums swollen or tender	Sensitivity to cold
Grinding teeth	Sensitivity to heat
Discolored teeth	Sensitivity to sweets
Clicking or popping jaw	Sensitivity when biting
Loose teeth or broken fillings	Sensitivity when brushing
Food collection between teeth	Chew on one side of mouth

Thank you, Please Fill Out Other Side As Well →

----------Medical History----------

Physician Name:_____

Phone #: _____ Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin, Pondinim, and Redux. ☐ YES ☐ NO

Have you ever had any serious illnesses or operations? ☐ YES ☐ NO

If yes, please describe:_____

_____

Do you use tobacco? ☐ YES ☐ NO If yes, how often? _____

Please circle type: Cigarettes_Cigars_Pipes_Chewing Tobacco

WOMEN: Are you pregnant? ☐ YES ☐ NO If yes, how long? _____

Are you nursing? ☐ YES ☐ NO On birth control? _____

Please *circle* any of the following which you have had, or presently have:

Aids/HIV	Heart Attack/Failure	Psychiatric Care
Anemia	Heart Murmur*	Radiation Treatment
Arthritis/Gout	Heart Pace Maker*	Renal Dialysis
Artificial Heart Valve*	Heart Trouble/Disease	Respiratory Disease
Artificial Joint*	Hemophilia	Rheumatic Fever*
Cancer	Hepatitis A	Scarlet Fever
Chemotherapy	Hepatitis B or C	Sinus Trouble
Congenital Heart Disorder	High Blood Pressure	Stroke
Cortisone Treatments	Hypoglycemia	Swelling of Limbs
Diabetes	Kidney Problems	Swollen Neck Gland
Drug Addiction	Leukemia	Thyroid Disease
Epilepsy or Seizures	Liver Disease	Tonsillitis
Excessive Bleeding	Low Blood Pressure	Tuberculosis
Fainting or Dizziness	Lung Disease	Tumors or Growths
Frequent Headaches	Mitral Valve Prolapse*	Ulcers
Glaucoma	Pain in Jaw Joints	Weight Loss-Unexplained

Have you ever had any serious illness not listed above? ☐ YES ☐ NO

If yes, please explain: _____

_____

----------MEDICATIONS----------

Important Are you currently taking aspirin? ☐ YES ☐ NO

Please list all medications you are currently taking and the correlating diagnosis: _____

_____

Are you taking Osteoporosis Medication: ☐ YES ☐ NO

If yes, how long? _____. Please circle the medication below:

Fosamax (Alendronate), **Boniva** (Ibandronate), or **Actonel** (Residronate)

----------ALLERGIES----------

Important Please check all that apply:

☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine

☐ Latex ☐ Local Anesthetic ☐ Iodine

☐ Erythromycin ☐ Barbiturates (sleeping pills) ☐ Sulfa

☐ Other (please specify): _____

_____

PLEASE PROVIDE US WITH YOUR PHARMACY INFORMATION BELOW:

Pharmacy Name : _____

Phone #: _____

----------OFFICE POLICIES----------

APPOINTMENT POLICY

If the need to reschedule or cancel an appointment arises, we request at least 48 hours notification. If you do not notify us with at least 24 hours notice, you will be charged $75.00 hour scheduled.

FINANCIAL POLICY

Payment is due at the time of service, unless prior financial arrangements have been made. If you are interested in making payment arrangements please ask our office for informat about our third party financing programs. We are happy to provide you with an application. These programs do require pre-approval. Please come to your appointment prepared to in full for your treatment unless you have been pre-approved. For your convenience we accept MC, VISA, checks (with valid ID) and cash.

INSURANCE POLICY

We accept many dental insurance plans. As a complementary service, we will file your treatment plan with your insurance company. We will estimate your portion based on the information your insurance company provides to us and that amount will be due at the time of service. Our estimates may differ somewhat from your insurance company's final calculations; therefore the amount due may be adjusted accordingly. All procedures that are not covered by insurance are ultimately the patient's responsibility. Any insurance clair unpaid after 60 days will automatically become the responsibility of the patient. Please note: You will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

CONSENT

The undersigned hereby authorizes the office to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosi the patient's dental needs. I also authorize the doctor (with my informed consent) to perform any and all forms of treatments, medications, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and that I am fully responsi for all dental fees. I authorize this office to provide information to my insurance carrier regarding my treatment. I also assign all insurance benefits to the doctor. Any payments received by the doctor from my insurance company will be credited to my account or returned to me if I had paid the dental fees incurred. I further understand that a late charge will added to any overdue balance.

PATIENT'S SIGNATURE: _____ **DATE:**_____

Doctor's Signature: _____ **Date:** _____