Plaza Dental Group
FAMILY DENTISTRY
78-461 Hwy 111 La Quinta, CA 92253
Tel(760) 564-5455 Fax(760)564-3874
www.plazadentalgrp.com

Patients
Name_____DOB/age_____Marital Status_____
Parent/Guardian_____
Address_____City_____Zip_____
Home Tel_____Cell_____Email_____
SS#_____DL#_____
Employer_____Occupation_____ Phone_____
Employer address_____City_____Zip_____
Do you have any objection to being contacted at you place of work?_____
Spouse_____DOB/age_____SS#_____DL#_____
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#_____

Have you ever had any unfavorable reaction from anesthetics? 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, sweets? Yes___No___
If yes, please explain_____
Have you had Dental X-Rays 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?_____
_____
Fears?_____
Finances?_____
Time?_____
Do you have any objection to X-Rays or Fluoride Treatment? Yes___No____
If yes, please explain_____
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. Johns Wort? Yes___ No___
If so, what?_____
Are you taking any medications? Birth Control or hormones? Yes___No___
If so, what?_____
Are you sensitive or allergic to any medications? Yes___No___
If so, what?_____
Do you have a Heart Condition? Yes___No___
If so, do you require antibiotic before Dental Treatment? Yes___No___
Are you taking Fosamax, Actonel, or Boniva? Yes___No___
If you smoke, how many packs per day?_____
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 Disorders**
Yes__No__ Nervous Disorder	**Yes__No__Radiation Treatment**	**Yes__No__Glaucoma (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 Trans. Disease	**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 or have been told you have a Heart Murmur?
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 of nitrous oxide sedation and to perform such operations a 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. If 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 UNDESTAND 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)