SAN DIEGO Smiles

THE ART OF DENTISTRY WITH A PERSONAL TOUCH

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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health

WELCOME

Patient Information

Date _____ Cell Phone _____ Home Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

E-Mail _____ Drivers Lic # _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed

Patient Employed by _____ Business Phone _____

How did you hear about us? _____

In case of emergency who should be notified? _____ Phone _____

Spouse's Name _____ Spouse's Business Phone _____

Dental History

Reason for today's visit _____

Date of last dental care _____ Date of last dental X-rays _____

What did you like most about any previous dentist? _____

What did you like least about any previous dentist? _____

Why did you leave your last dentist? _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking of popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food Collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

Authorization

Insurance Company _____ Phone # _____

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature _____ Date _____

Payment & Truth & Lending Statement

Cash Check Credit Card (MC, Visa, Discover, American Express)

I understand that I am financially responsible for all charges whether or not paid by insurance & all bills over 90 days will be subject to 1.5% per month service charge. I agree to pay Doctor's attorney's & collection fees & cost for any action required to collect a delinquent account.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Smile Assessment

Yes	No	
_____	_____	Do you like to smile and show your teeth?
_____	_____	Are you happy with the way your teeth look?
_____	_____	Do you have unsightly crowns or filings?
_____	_____	Do you feel your teeth are too long or too short?
_____	_____	Do you brush your teeth too hard?
_____	_____	Are you missing teeth?
_____	_____	Are you interested in improving the appearance of your teeth?
_____	_____	Are you interested in tooth replacement?
_____	_____	Are you familiar with the benefits of implants?
_____	_____	Are your teeth or gums sensitive?
_____	_____	Are your gums receding?
_____	_____	Are you anxious or fearful of treatment?
_____	_____	Are you interested in cosmetic treatment?
_____	_____	If there was a simple inexpensive way to whiten your teeth, would you be interested?

If you could wave a magic wand and change one thing about your smile, what would it be?

_____

I authorize Dr. Kurt Christensen and Dr. Steven E. Krause the use of my before and after Pictures for the purposes of dental scientific articles and programs, web sites to show other patients and for use in advertising.

Signature _____

CONFIDENTIAL HEALTH HISTORY

Email : _____ Phone : _____

Patient Name:_____ Date of Birth:_____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: _____

V. ARE YOU OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list all current medications: _____

VI. WOMAN ONLY

Yes No Are you or could you be pregnant?
If YES, what month?_____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain_____

Yes No Have you ever been pre-medicated for dental treatment? If yes, why_____

Yes No Have you ever taken Fen-phen? If YES, when_____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature:_____ Date:_____

Physician's Name:_____ Phone Number:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and /or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

_____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____