STUDIO CITY
DENTAL GROUP®
Serving Los Angeles since 1956

PATIENT REGISTRATION

ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Ph: _____ Work Ph: _____ Ext.: _____ Cell Ph: _____

Birth Date: _____ Soc. Sec.: _____ Driver's Lic.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Ins. Policy Holder ☐ Secondary Ins. Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Ph: _____ Work Ph: _____ Ext.: _____ Cell Ph: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Driver's Lic.: _____

Email: _____ ☐ I would like to receive correspondences via email

Section 2

Today's Visit reason: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Referred by: _____

Section 3

Occupation: _____

Business Address: _____

_____

Business Phone: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State Zip: _____

Rem Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State Zip: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State Zip: _____

Rem Benefits: _____ Rem. Deduct: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If Yes: _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If Yes: _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If Yes: _____
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If Yes: _____
		_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If Yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If Yes: _____
Are you on a special diet?	☐ Yes ☐ No	If Yes: _____
Do you use tobacco?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	If Yes: _____

Women, are you...:
☐ Pregnant / Trying to get pregnant
☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics ☐ Other: _____

Do you have, or have you had, any of the following:

AIDS / HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No
Alzhemier's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis / Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells / Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack / Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold Sores / Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble / Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
			Yellow Jaundice ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes: _____

Consent

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

This is to certify that I consent to the performing of whatever dental procedures may be decided upon to be necessary or advisable by Studio City Dental Group. I hereby authorize Studio City Dental Group to release any and all dental and medical information to insurance carrier(s) for the purpose of claims evaluation and processing. I hereby authorize my insurance carrier(s) to pay directly to Studio City Dental Group the benefits otherwise payable to me. I hereby authorize Studio City Dental Group to obtain my credit history. I understand that I am financially responsible for all charges. I authorize Studio City Dental Group to use my photographs, x-rays, and other dental records for educational purposes. These authorizations remain valid until revoked in writing. I understand that each patient is unique and that dental treatment cannot be guaranteed. I will inform Studio City Dental Group of any changes in my personal information.

X _____ Date: _____

Signature of Patient, Parent or Guardian