

Serving Los Angeles since 1956

PATIENT REGISTRATION

ID: _____ Last Name: _____ Middle Initial: _____ First Name: 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: _____ 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: _____ _____ Work Ph: ____ _____ Ext.: _____ Cell Ph: ____ Home Ph: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Sex: ☐ Male ☐ Female Birth Date: _____ Age: ____ Soc. Sec.: ____ Driver's Lic.: ____ — Section 2 — Section 3 — Sect Occupation: Todav's Visit reason: Business Address: Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time Business Phone: Primary Insurance Information Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured Soc. Sec.: _____ Insured Birth Date: _____ Ins. Company: Employer: _____ Address: Address: Address 2: Address 2: City, State Zip: 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: _____ Ins. Company: _____ Address: _____ Address: Address 2: _____ Address 2: _____ City, State Zip: City, State Zip: Rem Benefits: Rem. Deduct:

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 Anaphylaxis Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Storible Yes No No No No No No No N	or answering the fo ll ov	wing question	S.								
Have you ever had a serious head or neck injury? Yes No If Yes:	Are you under a physician's care now?				□ Yes	1 🗆	No If Yes:				
Are you taken, or have you taken, Phen-Fen or Redux? Yes No If Yes:	Have you ever been hospitalized or had a major operation?				☐ Yes	. □ I	No If Yes:				
Are you taken, or have you taken, Phen-Fen or Redux? Yes No If Yes:	Have you ever had a serious head or neck injury?					. 🗆 :	No If Yes:				
Do you take, or have you taken, Phen-Fen or Redux? Yes No If Yes:					□Yes	. n					
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet?	Are you taking any n	realcations, pi	ns of drugs.		□ 1C3	. Ш	10 II 163				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet?	Do you take or have	vou taken Ph	an-Ean ar Radi	ıv?	□Vos		— If Vest				
Are you as tobacco? Yes No If Yes; Women, are you	·										
Do you use controlled substances?						; <u></u>	No If Yes:				
	Are you on a special diet?					- I	No If Yes:				
							No				
Women, are you: Pregnant / Trying to get pregnant Are you allergic to any of the following: Acyliric Metal Latex Sulfa Drugs	·					. 🗆 :	No I f Yes:				
Pregnant / Trying to get pregnant Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Doyou have, or have you had, any of the following: AlDS / HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No Alzhemier's Disease Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Easily Winded Yes No Herpetis Bor C Yes No Rheumatic Fever Yes No Angina Yes No Emphysema Yes No Emphysema Yes No Hepatitis A Yes No Rheumatic Fever Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Siningles Yes No Siningles											
Pregnant / Trying to get pregnant Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Doyou have, or have you had, any of the following: AlDS / HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No Alzhemier's Disease Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Easily Winded Yes No Herpetis Bor C Yes No Rheumatic Fever Yes No Angina Yes No Emphysema Yes No Emphysema Yes No Hepatitis A Yes No Rheumatic Fever Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Siningles Yes No Siningles							C.I. C.II. :				
Do you have, or have you had, any of the following: ADS / HIV Positive							_				
Do you have, or have you had, any of the following: AIDS / HIV Positive				1				· ·			_
AIDS / HIV Positive	□ Nursing □ Taking oral contraceptives □ □ Local Anest						Other:				
AIDS / HIV Positive											
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 Anamia Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Anamia Yes No Easily Winded Yes No High Blood Pressure Yes No Renal Dialysis Yes No Arthritis / Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Sinde Cell Disease Yes No Arthritis / Gout Yes No Excessive Thirst Yes No High Cholesterol Yes No Sickle Cell Disease Yes No Arthritis / Gout Yes No Excessive Thirst Yes No Hyogotemia Yes No Sinus Trouble Yes No Sinus Trouble Yes No Recating Problems Yes No Frequent Cough Yes No Frequent Cough Yes No Frequent Cough Yes No Frequent Diarrhea Yes No Equipated Pressure Yes No Stroke Yes No No Stroke Yes No Stroke Yes No Stroke Yes No No Stroke Yes	Do you have, or hav	e you had, any	of the fo ll owir	ng:							
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 Epilepsy or Seizures Yes No High Gholesterol Yes No Scarlet Fever Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Artificial Joint Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scide Cell Disease Yes No Artificial Joint Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scide Cell Disease Yes No Artificial Joint Yes No Excessive Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Sinus Trouble Yes No Renation Yes No Sinus Trouble Yes No Renation Yes No Yes No Renation Yes No Yes No Yes No Yes No Yes No Yes No Yes No	AIDS / HIV Positive	☐ Yes ☐ No	Cortisone Medi	cine [□ Yes □ No	1	Hemophilia	□Yes	□ No	Radiation Treatments	□ 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 Scalet Fever Yes No Arthritis / Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Shingles Yes No Shingles Yes No Shingles Yes No Shingles Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Spina Bifida Yes No Spina Bifida Yes No Spina Bifida Yes No Strowach/Intestinal Disease Yes No Strowach/Intestinal Disease Yes No Strowach/Intestinal Disease Yes No Strowach/Intestinal Disease Yes No Swelling of Limbs Yes No No No No No No No N	Alzhemier's Disease	☐ Yes ☐ No	Diabetes	[□ Yes □ No		Hepatitis A	☐ Yes	□No	•	☐ Yes ☐ No
Angina Yes No Emphysema Yes No High Blood Pressure Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Scarlet Fever Yes No Arthritis / Gout Yes No Excessive Bleeding Yes No Hives or Rash Yes No Scarlet Fever Yes No Arthritial Heart Valve Yes No Excessive Thirst Yes No Hives or Rash Yes No Sindle Cell Disease Yes No Sindle Cell Disease Yes No Sinus Trouble Yes No	Anaphylaxis	☐ Yes ☐ No	Drug Addiction]	□ Yes □ No		Hepatitis B or C	☐ Yes	□No	•	☐ Yes ☐ No
Arthritis / Gout	Anemia		1				•		1		
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hilly sor Rash Yes No Shingles Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Sinus Trouble Yes No Shingles Yes No No Sickle Cell Disease Yes No No Yes No Sinus Trouble Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Stowach/Intestinal Disease Yes No No Stowach/Intestinal Disease Yes No Stowach/Intestinal Disease Yes No No Stowach/Intestinal Disease Yes No No No No No No No N	•		' '			- 1	3		1		
Artificial Joint		☐ Yes ☐ No	Epilepsy or Seizures		□ Yes □ No	- 1	•		1		
Arthinal Yes No Fainting Spells / Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stroke Yes No Thyroid Disease Yes No No No No No No No N	Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding		□ Yes □ No		Hives or Rash		1	-	
Astma Yes No Fainting Spells / Dizziness Yes No Irregular Heartbeat Yes No Spina Bifida Yes No Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Stroke Yes No Thurs of Disease Yes No No No No No No No N	Artificial Joint	☐ Yes ☐ No	Excessive Thirst		□ Yes □ No		Hypoglycemia	☐ Yes	□No		
Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Stroke Yes No No No No No No No N	Asthma	☐ Yes ☐ No	Fainting Spells / Dizziness 🔲 Ye		□ Yes □ No		Irregular Heartbeat		I		
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stroke Yes No Reathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Swelling of Limbs Yes No Swelling of Limbs Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Cancer Yes No Glaucoma Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Thyroid Disease Yes No Tonsillitis Yes No No Yes No Tumors or Growths Yes No No Yes No No Yes No No Yes No No No No No No No N	Blood Disease	☐ Yes ☐ No	Frequent Cough		□ Yes □ No		Kidney Problems	☐ Yes	□No	•	
Bruise Easily	Blood Transfusion	☐ Yes ☐ No	·		□ Yes □ No		Leukemia	☐ Yes	□No		
Bruise Easily	Breathing Problems	☐ Yes ☐ No	·		□ Yes □ No			☐ Yes	□No	Swelling of Limbs	□ Yes □ No
Chemotherapy Yes No	Bruise Easily		•			I				-	□ Yes □ No
Chest Pains	Cancer	☐ Yes ☐ No	Glaucoma □ Ye		□ Yes □ No		Lung Disease	☐ Yes	□No	Tonsillitis	□ Yes □ No
Cold Sores / Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Ulcers Yes No Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Yellow Jaundice Yes No	Chemotherapy	☐ Yes ☐ No	*		□ Yes □ No		Mitral Valve Prolapse	☐ Yes	□No	Tuberculosis	□ Yes □ No
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease Yes No Convulsions Yes No Heart Trouble / Disease Yes No Psychiatric Care Yes No Yellow Jaundice Yes No No Yellow Jaundice Yes No No No Yellow Jaundice Yes No No Yellow Jaundice Yes No No Yellow Jaundice Yes No No No Yellow Jaundice Yes No No Yellow Jaundice Yes Yes No Yellow Jaundice Yes Yes No Yellow Jaundice Yes Yes	Chest Pains	☐ Yes ☐ No	Heart Attack / F	ailure [□ Yes □ No		Osteoporosis	☐ Yes	□No	Tumors or Growths	☐ Yes ☐ No
Convulsions	Cold Sores / Fever Blisters	☐ Yes ☐ No	Heart Murmur	[□ Yes □ No		Pain in Jaw Joints	☐ Yes	□No	Ulcers	☐ Yes ☐ No
Have you ever had any serious illness not listed above?	Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemake	er [□ Yes □ No		Parathyroid Disease	☐ Yes	□No	Venereal Disease	☐ Yes ☐ No
onsent the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can angerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Convulsions	☐ Yes ☐ No	Heart Trouble /	Disease [□ Yes □ No	I	Psychiatric Care	☐ Yes	□ No	Yellow Jaundice	☐ Yes ☐ No
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can angerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	Have you ever had an	y serious i ll ne	ss not listed ab	ove? 🗆 \	∕es □ No	If ye	25:				
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can angerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	onsent										
angerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.		vledge, the gu	estions on this	form hav	e been acc	urate	elv answered. Li	understand	d that pro	oviding incorrect inform	nation can
	•						•		•	_	
			•	•			-	_			by Studio (

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

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.

Group of any changes in my personal information.	
XSignature of Patient, Parent or Guardian	Date: