KIM ROSEN, DDS

FAMILY & COSMETIC DENTISTRY

27420 Tourney Road, Ste 270 ● Valencia, CA 91355 ● 661-255-2545

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION

Name: LAST:_____FIRST_____M.I._____NICKNAME_____

Address: STREET_____

CITY_____STATE_____ZIP_____

DOB: _____ ☐ Male ☐ Female Social Security #: _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Spouse/Parent Name: _____

Home Phone (_____)_____ Work Phone (_____)_____ ext._____

Mobile Phone(_____)_____ Email: _____

How would you like to receive appointment reminders? ▫ Phone Call ▫ Email ▫ Text

Emergency Contact Name: _____ Phone: (_____)_____

Employer: _____ May we contact you at work? ☐ Yes ☐ No

How did you hear about us? _____

DENTAL INSURANCE

Primary Dental Carrier

Insurance Co: _____ Insurance Phone #: _____

Subscriber Name: _____ Social Security #: _____ DOB: _____

Employer: _____Group #: _____Relation to patient: _____

Secondary Dental Carrier

Insurance Co: _____ Insurance Phone #: _____

Subscriber Name: _____ Social Security #: _____ DOB: _____

Employer: _____Group #: _____Relation to patient: _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the health history page is correct to the best of my knowledge.

Signature: _____ Date: _____

If patient is under 18, Parent/Responsible Party's Signature:_____

Relation to Patient: _____

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Patient's Name: _____ Date: _____

HEALTH HISTORY

Please mark "Yes" or "No" to indicate if you have had any of the following

CONDITIONS

Abnormal Bleeding	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	**IF FEMALE**	
Angina Pectoris	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Are you on birth control?	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	If yes, how many weeks?	_____
Asthma	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No		
Blood Transfusion	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No	**MEDICATIONS:** (List any medications you are currently taking)	
Cancer	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No		
Chemotherapy	☐ Yes ☐ No	Seizures	☐ Yes ☐ No		
Colitis	☐ Yes ☐ No	Shingles	☐ Yes ☐ No		
Congenital Heart Defect	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No		
Difficulty Breathing	☐ Yes ☐ No	Sjogren's Syndrome	☐ Yes ☐ No		
Drug/Alcohol Abuse	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No		
Facial Surgery	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No		
Fainting Spells	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No		
Fever Blisters	☐ Yes ☐ No				
Frequent Headaches	☐ Yes ☐ No				
Glaucoma	☐ Yes ☐ No	**ALLERGIES**			
HIV/AIDS	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No		
Heart Attack	☐ Yes ☐ No	Codeine	☐ Yes ☐ No		
Heart Murmur	☐ Yes ☐ No	Dental Anesthetics	☐ Yes ☐ No		
Heart Surgery	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No		
Hemophilia	☐ Yes ☐ No	Latex	☐ Yes ☐ No		
Hepatitis A	☐ Yes ☐ No	Metals	☐ Yes ☐ No		
Hepatitis B	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No		
Hepatitis C	☐ Yes ☐ No	Sulfa	☐ Yes ☐ No		
High Blood Pressure	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No		
Joint Replacement	☐ Yes ☐ No	Other: _____			
Kidney Problems	☐ Yes ☐ No	_____			

Patient's Signature: _____ Date: _____

If patient is under 18, Parent/Responsible Party's Signature: _____

Doctor Review: _____

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DENTAL EVALUATION

Patient's Name: _____ Date: _____

Is there anything about your smile that you don't like? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing, biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you be interested in enhancing your smile with whiter, more aligned teeth? ▢ Yes ▢ No

If nervous, would you like to have your dentistry done with laughing gas (nitrous oxide)? ▢ Yes ▢ No

Is there anything about your mouth that concerns you now? ▢ Yes ▢ No

If yes, please explain:_____

_____

When were you last seen at the Dentist? What treatment was done? _____

_____

Were X-Rays taken at this last visit? ▢ Yes ▢ No

Have you ever had orthodontic treatment? ▢ Yes ▢ No

Do you use dental floss or toothpicks? ▢ Yes ▢ No

Have you ever had your wisdom teeth removed? ▢ Yes ▢ No

Do your gums ever bleed? ▢ Yes ▢ No

Are any of your teeth loose? ▢ Yes ▢ No

Do you have any swelling, sores or blisters in your mouth? ▢ Yes ▢ No

Have you ever been told that you have gum disease? ▢ Yes ▢ No

Have you ever visited a periodontist (gum specialist)? ▢ Yes ▢ No

Do you smoke? ▢ Yes ▢ No

Do you feel you have unpleasant breath at times? ▢ Yes ▢ No

Are you interested in using sedatives while dental treatment is being performed? ▢ Yes ▢ No

How would you describe your dental health on a scale of 1-10 with 10 being the best? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant?

Is there anything that we can do to make your dental visits more comfortable? _____

_____

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OFFICE POLICY

NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make every effort to keep your appointments. You must notify us within 48 hours if you need to reschedule or cancel your appointment. A $75 fee will be assessed for all cancellations or missed appointments within less than 48 hours.

PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that incurred due to a missed appointment.
- I received my insurance check and do not send it to the office.

By signing this, I have read and understand the above policy.

_____ _____

Patient Signature Date