David Schlang, DDS

Cosmetic and Implant Dentistry

11645 Wilshire Blvd., Suite 703, Los Angeles, CA 90025 310-477-2488 Fax: 310-477-5288

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name _____ M. I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date_____ Age _____ Soc. Sec. # _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____)_____Cell (_____)_____ Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic. # _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact: _____ Tel. (_____)_____ Relation _____

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother Other: _____

(If self, skip to next section)

Name _____ Soc. Sec. # _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (if different from above):

Name _____ Relation _____ Soc. Sec. # _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel Soc. Sec. # _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ☐ Full Time ☐ Part Time ☐ Not School Name/Address _____

☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single

Employed: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

PRIMARY INSURANCE COMPANY

Insurance Type: ☐ Dental ☐ Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

Insurance Type: ☐ Dental ☐ Medical

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

DENTAL INFORMATION

Reason for today's visit: _____ Are you in pain? ☐ Yes ☐ No For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

☐ Discomfort, clicking, or popping in jaw	☐ Lost/broken filling(s)	☐ Stained teeth	☐ Difficulty closing jaw
☐ Red, swollen, or bleeding gums	☐ Teeth grinding/clenching	☐ Locking jaw	☐ Difficulty opening jaw
☐ A removable dental appliance	☐ Ringing in ears	☐ Bad breath	☐ Loose/shifting teeth
☐ Blisters/sores in or around the mouth	☐ Broken/chipped tooth	☐ Burning tongue/lips	☐ Food caught in teeth
☐ Prolonged bleeding from an injury/extraction	☐ Gum disease	☐ Toothache	☐ Swelling/lumps in mouth
☐ Recent infections or sore throat	☐ Other:		

☐ My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweet ☐ Biting

Last dental exam _____ Last dental x-rays _____ Times a day you brush?_____ Times a week you floss?_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ☐ Yes ☐ No

What type of toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard

MEDICAL HISTORY

Are you in good health? ☐ Yes ☐ No Height _____ Weight _____ Are you under the care of a physician? ☐ Yes ☐ No

Have you had any illnesses, operations, or been hospitalized in the past five years? ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Rheumatic fever	☐	☐	Are you immunosuppressed? (possibly from transplant?)	☐	☐	Problems with immune system? (possibly from med. / surg.)	☐	☐	Low blood sugar?
☐	☐	Mitral valve prolapse?							☐	☐	Kidney trouble
☐	☐	Heart murmur	☐	☐	Asthma	☐	☐	Bleeding tendency	☐	☐	Are you on dialysis?
☐	☐	High blood pressure	☐	☐	Hay fever / Sinus problems	☐	☐	Jaundice / Liver disease	☐	☐	Arthritis / Joint diseas
☐	☐	Low blood pressure	☐	☐	Snoring / Sleep apnea	☐	☐	Hepatitis	☐	☐	Osteoporosis
☐	☐	Chest pain / Angina	☐	☐	Respiratory problems	☐	☐	Infectious mononucleosis	☐	☐	Osteonecrosis
☐	☐	Heart attack(s)	☐	☐	Tuberculosis	☐	☐	Gallbladder trouble	☐	☐	Stomach ulcers
☐	☐	Irregular heart beat	☐	☐	Emphysema	☐	☐	Fainting spells	☐	☐	Contagious disease(s)
☐	☐	Cardiac pacemaker	☐	☐	Do you smoke?	☐	☐	Convulsions / Epilepsy	☐	☐	Delay in healing
☐	☐	Heart surgery	☐	☐	Do you use chewing tobacco?	☐	☐	Stroke	☐	☐	Anemia
☐	☐	Bronchitis / Chronic cough	☐	☐	Blood transfusion	☐	☐	Thyroid trouble	☐	☐	Tumor or growth
☐	☐	Chronic fatigue / Night sweat	☐	☐	Blood disorder	☐	☐	Diabetes	☐	☐	Radiation / Chemo
☐	☐	Difficulty climbing 1-2	☐	☐	Bruise easily	☐	☐	History of alcohol abuse	☐	☐	Are you on a diet?
☐	☐	flights of stairs	☐	☐	History of drug abuse	☐	☐	STDs	☐	☐	Contact lenses
☐	☐	Mental health problems	☐	☐	Eye disease / Glaucoma	☐	☐	Swollen ankles	☐	☐	Immune system probs.
☐	☐	Damage heart valves	☐	☐	Abnormal bleeding	☐	☐	Malignant hyperthermia			

MEDICATION AND ALLERGIES

Are you now taking or have you taken:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Nerve pills	☐	☐	Painkillers (including aspirin)	☐	☐	Muscle relaxers	☐	☐	Stimulants
☐	☐	Have you ever taken diet pills	☐	☐	Trainquilizers	☐	☐	Insulin	☐	☐	Antidepressants
☐	☐	Blood thinners (*Coumadin, Aspirin, Advil*)									
☐	☐	Any bone density medication or Bisphosphonates *(Aredia, Zometa, Fosamax, Actonel)*									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or have you had a reaction to:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic (numbing med)	☐	☐	Sodium pentothal
☐	☐	Valium or other tranquilizers	☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex
☐	☐	Soy	☐	☐	Eggs / Yolk	☐	☐	Sulfites	☐	☐	Amoxicillin

Please list any other medication or antibiotic you are allergic to:

Please list any other allergies other than drug allergies:

1-4 below for women only: (*women note: antibiotics (such as penicillin) may after the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.*)

1) Is there a possibility of pregnancy ☐ Yes ☐ No 2) Expected delivery date: _____

3) Are you nursing? ☐ Yes ☐ No 4) Are you taking birth control pill? ☐ Yes ☐ No

I certify that I have read and I understand the questions above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor or any other member of his /her staff responsible for any errors/omissions that I've made in the completion of this form.

Signature of patient: X (Parent or Guardian if minor) **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees and court costs.

Signature of patient: (Parent or Guardian if minor) X **Date:** X

This signature on file is my authorization for the release of the information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) X **Date:** X

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 any questions I may have regarding this Notice.

Signature of patient: (Parent or Guardian if minor) X **Date:** X