

WELCOME

SEA COUNTRY DENTAL

32211 Chelan Canyon, Suite D
Marina Area, CA 92077
(619) 498-7000 • Fax: (619) 498-9770

1

ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2

INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

PLEASE CONTINUE ON BACK

DENTAL INFO

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How Long? _____

Please indicate any of the following problems:

- | | | |
|--|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw. | <input type="checkbox"/> Lost/Broken Filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums. | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Locking Jaw |
| <input type="checkbox"/> Sensitive tooth, teeth or gums. | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Blisters/Sores in or around the mouth. | <input type="checkbox"/> Broken/Chipped tooth | |
| <input type="checkbox"/> Other: _____ | | |

Do you require pre-medication? Yes No Don't know

Previous Dentist: _____ (_____) _____
 Name Phone#

Last Dental Exam: _____/_____/_____

Last Dental X-rays: _____/_____/_____

Times a day you brush? _____

Times a week you floss? _____

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Have you taken any medication or drugs during the past two years? Yes No

Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage _____

Have you ever taken prescription medications for weight loss (diet pills)? Yes No

If yes, did you take any of the following:

Yes	No	Fen-Phen (Fenfluramine-Phentermine)
Yes	No	Pondiman (Fenfluramine)
Yes	No	Redux (Dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? Yes No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you use more than two pillows to sleep? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

Women. Are you: Pregnant? Yes, ___ Months No Nursing? Yes No Taking birth control pills? Yes No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that this practice provides space, equipment, support personnel, and administrative services to facilitate each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

Signature _____ Date _____/_____/_____

Adult Patient Parent or Guardian Spouse

UPDATE OFFICE FILE	
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____
Initials _____	Date _____