



Corporate Pointe Dental

100 Corporate Pointe, Suite 170
Culver City, CA 90230

Thank you for selecting our dental office. We will strive to provide you with the best possible care. To help us meet all your dental goals, please complete these forms.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthday _____ Soc. Sec # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

What is the best number to reach you at? _____ What Time _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Spouse Name _____ Occupation _____ Any Children? _____

If Full time Student, Name of School/ College _____ City _____ State _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Is this Person Currently a Patient in our Office? Yes No

Dental Insurance Information

Will some of your dental work be covered by insurance? Yes No

Name of Insured _____ Relationship _____

Birthdate _____ Social Security # _____ Work Phone _____

Name of Employer _____ Union or Local # _____

Insurance Company _____ Group # _____

Ins Co Address _____ City _____ State _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE ? Yes No IF YES, COMPLETE THE FOLLOWING...

Name of Insured _____ Relationship _____

Birth date _____ Social Security # _____ Work Phone _____

Name of Employer _____ Union or Local # _____

Insurance Company _____ Group # _____

Ins Co Address _____ City _____ State _____

Dental History (CONFIDENTIAL)

Correct answers to the following questions will allow our office to treat you on a more individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Do you visit the dentist regularly? Yes No

Date of last dental: Visit _____ Exam _____ X-rays of all of your teeth _____

How often do you brush? _____ Do you avoid brushing any part of your mouth? _____

Do you brush your teeth vigorously lightly My brush is: Soft Medium Hard

Does dental treatment make you nervous? No Slightly Moderately Extremely

What can we do to make you more comfortable? _____

Have you ever been treated for periodontal disease? (Gum disease, pyorrhea, trench mouth) Yes No

Do you have any of the following:

MOUTH	Yes	No	TEETH	Yes	No
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breathe	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blister, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>	Food Impaction	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any missing teeth? Yes No If so, how long have they been missing? _____

Why didn't you have them replaced? _____ Was it ever suggested? _____

Have you ever had braces? Yes No If yes, what calendar years? _____

Do you chew on both sides of your mouth? Yes No If no, please explain _____

Do you have a tired feeling in your face while chewing or at the end of the day after considerable talking? Yes No

Have you ever had a reaction to a dental anesthetic or any problems with dental work? Yes No If yes, please explain _____

Are you aware of your jaw clicking or popping while you are eating or yawning? Yes No How often? _____

Do you have headaches, chronic neck or shoulder pain? Yes No If yes, where? _____

Do you clench or grind your teeth? Yes No Has anyone made you aware that you do this? _____

Do you know that decay and gum disease can occur without your being aware of it? Yes No

Are you having any discomfort at this time? Yes No If yes, please explain _____

Is there anything else you would like us to know? _____

Patient Signature _____ Date _____

Health History (CONFIDENTIAL)

Have there been any problems in your general health within the past 5 years? (Serious illness, hospitalization, surgery, etc.)

Yes No If yes, please explain _____

Have you had any form of Cancer? Yes No If so what type? _____

Date of last medical check up _____ Attending Physician _____

Date of last blood test _____ Attending Physician _____

Are you currently under a physician care now? Yes No If yes, please explain _____

Please list any medications you are currently taking (vitamins, drugs, pain pills, herbs, etc.) _____

Are you required to take any medication before having dental work done? Yes No If yes, what? _____

Have you had a positive test for the aids virus (HIV+)? Yes No What date? _____

Physician's name _____ Phone # _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever, Rheumatic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur, Mitral valve prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble, Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in chest, Shortness of breathe | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure, Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder, Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Positive test for venereal disease | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores, Herpes incident | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble | <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily, Abnormal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells, Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B or C | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice, Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores that do not heal in 1week | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant | <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Back trouble or surgery | <input type="checkbox"/> | <input type="checkbox"/> | Whiplash injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke _____ pk per _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | Drug addiction |

FOR WOMEN ONLY

Are you pregnant? Due Date _____ Taking birth control pills?

Do you have any discase, condition or problem not listed above that we should know about? _____

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING?

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin | <input type="checkbox"/> | <input type="checkbox"/> | Cocaine |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Pain Pills | <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> | Vinyl | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa |
| <input type="checkbox"/> | <input type="checkbox"/> | Tylenol | <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen | <input type="checkbox"/> | <input type="checkbox"/> | Acrylic |

Anything not listed above _____

Patient Signature _____ Date _____