



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

Occupation _____ Spouse Name _____ 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 _____

Please provide your e-mail address: _____

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 _____

CORPORATE POINTE DENTAL

APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept a definite arrangement for appointments. Once an appointment is made, please remember this time is reserved for you. **AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE A \$50 CHARGE FOR THE BROKEN APPOINTMENT WILL BE MADE.**

HYGIENE APPOINTMENTS

Our hygienists are extremely professional and highly paid. They are paid whether they are with a patient or not. **BROKEN APPOINTMENT CHARGE** will be applied when less than **24 hour notice** is given for rescheduling hygiene appointments.

INSURANCE

To avoid misunderstanding regarding dental insurance, we wish our patients to know that **ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT** and that **PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.** We will prepare necessary forms or reports to help you to obtain your benefits from insurance companies. **WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT THE INSURANCE COMPANIES WILL PAY ALL OUR FEES.**

RETURNED CHECKS

There is a **\$50** charge for **ALL CHECKS RETURNED** to our office from the bank for any reason.

PROFESSIONAL FEES

Professional fees are to be paid when services are rendered unless previous financial arrangements have been made.

If you are completing this registration for another person, what is the relationship?

Signature of patient/responsible party

Dentist

Date

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 _____

