PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services.
To assist us in serving you, please complete both sides of this form.

Name____ Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Preferred Name____________________________________ SS #_____-____-_____ Driver's License #_______________

Address____ Occupation ____

City________________________ State____ Zip___________ Employer/School ____________________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor Employer/School Address _____________________________

☐ Separated ☐ Divorced ☐ Partnered for ___ years Employer/School Phone ______________________________

Spouse's name______________________________________ Spouse's Employer _______________________________

Date of Birth _____/_____/_____ SS # _____-____-_____ Spouse's Phone (____) ___________________

CONTACT INFORMATION

Cell (____) _________________ Home (____) __________________ Work (____) __________________ Ext____

Email ____ Best time and place to reach you? ______________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name____ Relationship ____________________ Phone (___) __________________

WHOM MAY WE THANK FOR REFERRING YOU?

☐ Doctor _________________ ☐ Patient ___________________ ☐ Internet__________________ ☐ Other ___________________

CANCELLATION POLICY

Your appointment is exclusively reserved for "You". If you are unable to keep your appointment please provide us with a 48-hour notice to avoid a late cancellation or missed appointment fee. ___________
Initial

DENTAL INSURANCE

Primary Dental Insurance ____________________________ **Secondary Dental Company** ____________________________

Address ____ Address ____

Phone (____) ___________________ Phone (____) ___________________

Group # ___________ Subscriber ID# ____________________ Group # ___________ Subscriber ID# ____________________

Subscriber Name _____________________________________ Subscriber Name _____________________________________

SS# ______-____-______ Date of Birth _____/_____/_____ SS# ______-____-______ Date of Birth _____/_____/_____

Employer ____ Employer ____

____ ____ ____________________
Signature of Patient/Parent/Guardian Please print name of Patient/Parent/Guardian Date

HEALTH HISTORY

Name ____ Date of Birth ____/____/____ Social Security # _______-____-______

Reason for today's visit ____

Former Dentist____ City/State ____

Date of last dental visit _______________________________ Date of last dental X-Rays ___________________________________

How often do you floss? _____________________ How often do you brush? ____________________

Do you have, or have you had, any of the following?

DENTAL HISTORY

	YES	NO		YES	NO		YES	NO
Bad Breath	☐	☐	Food collection between teeth	☐	☐	Orthodontic Treatment	☐	☐
Bleeding Gums	☐	☐	Foreign Objects	☐	☐	Pain around ear	☐	☐
Blisters on lips or mouth	☐	☐	Grinding Teeth	☐	☐	Periodontal Treatment	☐	☐
Burning sensation on tongue	☐	☐	Gums swollen or tender	☐	☐	Sensitivity to cold	☐	☐
Chew on one side of mouth	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to heat	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets	☐	☐
Clicking or popping jaw	☐	☐	Loose teeth or broken filling	☐	☐	Sensitivity when biting	☐	☐
Dry Mouth	☐	☐	Mouth Breathing	☐	☐	Sores/growths in mouth	☐	☐
Fingernail Biting	☐	☐	Mouth pain, brushing	☐	☐			

MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Respiratory Disease	☐	☐
Anemia	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
Back Problems	☐	☐	Hepatitis Type	☐	☐	Special Diet	☐	☐
Bleeding abnormally, with			Herpes	☐	☐	Stroke	☐	☐
extraction or surgery	☐	☐	High Blood Pressure	☐	☐	Swollen Feet or Ankles	☐	☐
Blood Disease	☐	☐	Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Cancer	☐	☐	Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Chemical dependency	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Low Blood Pressure	☐	☐	Tumor/Growth on		
Congenital Heart Lesions	☐	☐	Mitral Valve Prolapse	☐	☐	head or neck	☐	☐
Cortisone Treatments	☐	☐	Nervous Problems	☐	☐	Ulcer	☐	☐
Cough, Persistent/Bloody	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐	Weight Loss	☐	☐
Emphysema	☐	☐	Radiation Treatment	☐	☐			

ALLERGIES

☐ Aspirin ☐ Latex or rubber dam

☐ Barbiturates (Sleeping pills) ☐ Local Anesthetic ("Novocaine")

☐ Codeine ☐ Penicillin

☐ Iodine ☐ Other ____________________

____

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: ______________________________________

____

____

Pharmacy Name ______________________________________

Phone (_____) _________________________

881 Alma Real Dr. Ste. T2
Pacific Palisades, CA 90272

PH: 310.459.2303
FX: 310.459.0015
thepalidentists.com
admin@thepalidentists.com

FINANCIAL POLICY

I understand it is my responsibility to pay the full amount for all dental treatment provided for my dependants and myself at the time of service.

I understand that filing insurance claims is a courtesy that Dr. Carly LeVine extends to all patients and there are no guarantees of any estimated coverage or payments. The insurance company will directly reimburse any covered benefits to the responsible party.

I understand that a $135 Broken Appointment Fee will be added to my account if I fail to provide at least 48-hour notice for cancelled or rescheduled dental appointments.

I understand that it is my responsibility to advise the office of any changes in the information regarding my patient information, insurance and health history.

Signature: ____ Date: _____________

Relationship:

Self
Parent or guardian
Spouse
Other ______________

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thepalidentists.com
admin@thepalidentists.com

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact: The Office Administrator at (310) 459-2303.

Patient's Consent

I, ____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Signature: _______________________________________ Date: ________________

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature **to revoke authorization**: ____________________________ Date: ________________

If this consent revocation is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.

The Federal HIPAA privacy compliance requirements are explained in this binder. When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.