Simi Hills Dental staff welcome you to our office!

PATIENT INFORMATION

DATE_____ SS#:_____

PATIENT NAME:_____
LAST NAME FIRST NAME MI

ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

SEX: M_____ F_____ AGE:_____ BIRTHDATE:_____

MARRIED:_____ SINGLE:_____

PATIENT EMPLOYER OR SHCOOL:_____

OCCUPATION:_____OFFICE PHONE NO,:_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE ? :_____

CONTACT INFO

CELL:_____ WORK:_____

HOME:_____ EMAIL:_____

HOW IS BEST TO CONTACT YOU? PLEASE CHECK ONES THAT BEST APPLY TO YOU.
CELL _____ HOME _____ WORK _____ TEXT MESSAGE _____ EMAIL _____

EMERGENCY CONTACT: NAME_____PHONE #:_____

RELATIONSHIP TO PATIENT:_____

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? : YES_____ NO_____

INSURANCE COMPANY NAME: _____

NAME OF POLICY HOLDER:_____ THEIR BIRTHDATE:_____

RELATIONSHIP TO PATIENT:_____ ID #:_____

GROUP ID: _____ GROUP NAME:_____

IS PATIENT COVERED BY ADDITIONAL DENTAL INSURANCE?: YES_____ NO_____

INSURANCE COMPANY NAME: _____

NAME OF POLICY HOLDER:_____ THEIR BIRTHDATE:_____

RELATIONSHIP TO PATIENT:_____ ID #:_____

GROUP ID: _____ GROUP NAME:_____

ASSIGNMENT OF RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT (S), HAVE INSURANCE COVERAGE WITH _____
INSURANCE COMPANY
AND ASSIGN DIRECTLY TO **DR. JUSTIN STOUT AND ASSOCIATES** ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. **DR. JUSTIN STOUT AND ASSOCIATES** MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR UNTIL I DECIDE TO LEAVE THE PRACTICE AND SWITCH DENTISTS.

_____ _____
SIGNATURE OF PATIENT/PARENT PRINT NAME OF PATIENT/PARENT

_____ _____
DATE RELATIONSHIP TO PATIENT

DENTAL HISTORY

PATIENT NAME: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____

FORMER DENTIST: _____ CITY/STATE: _____

DATE OF LAST DENTAL VISIT: _____ DATE OF LAST DENTAL X-RAY:_____

PLEASE CIRCLE "**YES**" OR "**NO**" TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

BAD BREATH	**YES/NO**	JAW PAIN OR TIREDNESS	**YES/NO**
BLEEDING GUMS	**YES/NO**	LIP OR CHEEK BITING	**YES/NO**
BLISTERS ON THE LIPS OR MOUTH	**YES/NO**	LOOSE TEETH OR BROKEN FILLINGS	**YES/NO**
BURNING SENSATION ON TONGUE	**YES/NO**	MOUTH BREATHING	**YES/NO**
CHEW ON ONE SIDE OF THE MOUTH	**YES/NO**	MOUTH PAIN, BRUSHING	**YES/NO**
CIGARETTE, PIPE, OR CIGAR SMOKING	**YES/NO**	ORTHODONTIC TREATMENT	**YES/NO**
CLICKING OR POPPING JAW	**YES/NO**	PAIN AROUND THE EAR	**YES/NO**
DRY MOUTH	**YES/NO**	PERIODONTAL TREATMENT	**YES/NO**
FINGERNAIL BITING	**YES/NO**	SENSITIVITY TO COLD	**YES/NO**
FOOD COLLECTIONG BETWEEN THE TEETH	**YES/NO**	SENSITIVITY TO HEAT	**YES/NO**
FOREIGN OBJECTS	**YES/NO**	SENSITIVITY TO SWEETS	**YES/NO**
GRINDING TEETH	**YES/NO**	SENSITIVITY WHEN BITING	**YES/NO**
GUMS SWOLLEN OR TENDER	**YES/NO**	SORES OR GROWTHS IN YOUR MOUTH	**YES/NO**

DO YOU HAVE ANY CONCERNS OF THE FOLLOWING:

SNORING	**YES/NO**
SHAPE OR COLOR OF TEETH	**YES/NO**

PLEASE ANY LET US KNOW IF YOU WOULD LIKE MORE INFORMATION ON ANY OTHER DENTAL CONCERNS.

_____

_____

_____

HOW OFTEN DO YOU FLOSS? _____

HOW OFTEN DO YOU BRUSH? _____

SIGNATURE: _____ DATE:_____

HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

PHYSICIAN'S NAME: _____ DATE OF LAST VISIT: _____

HAVE YOU EVER USED A BIPHOSPHONATE MEDICATION? COMMON BRAND NAMES ARE FOSAMAX, ACETONEL, ATELVIA, DIDRONEL BONIVA? **YES/NO**

HAVE YOU EVER TAKEN ANY OF THE GROUP DRUGS COLLECTIVELY REFFERED TO AS "FEN-PHEN"? THESE INCLUDE COMBINATIONS OF LONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE). PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). **YES/ NO**

IT IS REQUIERD THAT YOU CIRCLE "**YES**" OR "**NO**" ON ALL OF THE FOLLOWING :

AIDS/HIV	**YES/NO**	EPILEPSY	**YES/NO**	RADIATION TREATMENT	**YES/NO**
ANEMIA	**YES/NO**	FAINTING OR DIZZINESS	**YES/NO**	RESPIRATORY DISEASE	**YES/NO**
ARTHRITIS, RHEUMATISM	**YES/NO**	GLAUCOMA	**YES/NO**	RHEUMATIC FEVER	**YES/NO**
ARTIFICIAL HEART VALVES	**YES/NO**	HEADACHES	**YES/NO**	SCARLET FEVER	**YES/NO**
ARTIFICIAL JOINTS	**YES/NO**	HEART MURMUR	**YES/NO**	SHORTNESS OF BREATH	**YES/NO**
ASTHMA	**YES/NO**	HEART PROBLEMS	**YES/NO**	SINUS TROUBLE	**YES/NO**
BACK PROBLEMS	**YES/NO**	HEPITIS TYPE ____	**YES/NO**	SKIN RASH	**YES/NO**
BLEEDING ABNORMALL, WITH EXTRACTIONS OR SURGERY	**YES/NO**	HERPES	**YES/NO**	SPECIAL DIET	**YES/NO**
BLOOD DISEASE	**YES/NO**	HIGH BLOOD PRESSURE	**YES/NO**	STROKE	**YES/NO**
CANCER	**YES/NO**	JAUNDICE	**YES/NO**	SWOLLEN FEET OR ANKLES	**YES/NO**
CHEMICAL DEPENDENCY	**YES/NO**	JAW PAIN	**YES/NO**	SWOLLEN NECK GLANDS	**YES/NO**
CHEMOTHERAPY	**YES/NO**	KIDNEY DISEASE	**YES/NO**	THYROID PROBLEMS	**YES/NO**
CIRCULATORY PROBLEMS	**YES/NO**	LIVER DISEASE	**YES/NO**	TONSILITIS	**YES/NO**
CONGENITAL HEART LESIONS	**YES/NO**	LOW BLOOD PRESSURE	**YES/NO**	TUBERCULOSIS	**YES/NO**
CORTISONE TREATMENTS	**YES/NO**	MITRAL VALVE PROLAPSE	**YES/NO**	TUMOR OR GROWTH ON HEAD OR NECK	**YES/NO**
COUGH, PERSITENT OR BLOODY	**YES/NO**	NERVOUS PROBLEMS	**YES/NO**	ULCER	**YES/NO**
DIABETES	**YES/NO**	PACEMAKER	**YES/NO**	VENEREAL DISEASE	**YES/NO**
EMPHYSEMA	**YES/NO**	PSYCHIATRIC CARE	**YES/NO**	WEIGHT LOSS, UNEXPLAINED	**YES/NO**

WOMEN:

ARE YOU PREGNANT? **YES/NO** DUE DATE: _____ TAKING BIRTH CONTROL PILLS? **YES/NO** ARE YOU NURSING? **YES/NO**

MEDICATIONS:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE CORRELATING DIAGNOSIS: (USE BACK OF PAPER IF NEED)

_____

_____

_____

_____

_____
SIGNATURE OF PATIENT/PARENT

DATE: _____

ALLERGIES:

_____

_____

ARE YOU TAKING ANY BLOOD THINNERS (ASPIRIN, PLAVIX, COUMADIN, ETC.)? PLEASE LIST.

_____

_____

PHARMACY NAME: _____

PHONE (_____) _____

REVIEWED BY DOCTOR: _____ DATE:_____