Loyal DENTISTRY

624 W. Duarte Road, Suite 204
Arcadia, CA 91007
626.447.0934
www.loyaldentistry.com

*****How did you hear about our office?**_____

PATIENT REGISTRATION

First Name: _____Last Name: _____Middle Initial: _____
Patient is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name:_____Last Name: _____Middle Initial:_____

Address:_____

City:_____State: _____Zip: _____

Home Phone: _____Work Phone: _____EXT:_____Cell Phone:_____

Birth Date: _____Soc Sec#: _____Driver's Lic:_____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address:_____

City: _____State: _____Zip: _____

Home Phone: _____Work Phone:_____EXT:_____Cell Phone:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____Soc Sec#:_____Driver's Lic:_____

Email: _____ ◯ I would like to receive correspondences via email

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Primary Insurance Information

Name of Insured: _____Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date: _____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____State: _____Zip: _____ City: _____State: _____Zip:_____

Rem Benefits:_____Rem. Deduct:_____

Seconday Insurance Information

Name of Insured: _____Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date:_____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____State: _____Zip: _____ City: _____State: _____Zip:_____

Rem Benefits:_____Rem. Deduct:_____

Loyal DENTISTRY

624 W. Duarte Road, Suite 204
Arcadia, CA 91007
626.447.0934
www.loyaldentistry.com

MEDICAL HISTORY

Patient Name: _____Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication(s) that you may be taking, could have an important interrelationship with the dental work you will potentially receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or redux? ☐ Yes ☐ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, please explain: _____
Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____
Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____
Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant ☐ Yes ☐ No Taking oral conraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penecillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy/Seizure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestine	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Cold Sores	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Ulcers	○ Yes ○ No
Congenital Heart Prob	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No
Comments: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I t is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT,PARENT, OR GUARDIAN_____DATE: _____

Loyal DENTISTRY

624 W. Duarte Road, Suite 204
Arcadia, CA 91007
626.447.0934
www.loyaldentistry.com

DENTAL HISTORY

Patient Name: _____

Name of Previous Dentist and Location: _____

Date of Last Exam: _____

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/food? ☐ Yes ☐ No
4. Do you feel pain on any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck, or jaw injuries? ☐ Yes ☐ No
7. Have you ever experienced any of the following jaw problems?
   a. Clicking ☐ Yes ☐ No
   b. Pain (joint, ear, side of face) ☐ Yes ☐ No
   c. Difficulty in opening or closing ☐ Yes ☐ No
   d. Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
11. Have you ever had difficulty during tooth extractions in the past? ☐ Yes ☐ No
12. Do you wear partial or full dentures? ☐ Yes ☐ No
    If yes, date of placement:_____
13. Have you ever had Orthodontic treatment (Braces)? ☐ Yes ☐ No
14. Have you ever received oral hygiene instructions regarding the
    Care of your teeth and gums? ☐ Yes ☐ No
15. Have you had periodontal treatment (deep cleaning)? ☐ Yes ☐ No
16. Date of last Xrays: _____

Loyal DENTISTRY

624 W. Duarte Road, Suite 204
Arcadia, CA 91007
626.447.0934
www.loyaldentistry.com

COSMETIC QUESTIONNAIRE

With recent advancements in materials and techniques, many of our patients are asking more questions about cosmetic dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

Patient Name: _____Date: _____

Do you like the appearance of your teeth?	☐ Yes	☐ No
Are your teeth as straight as you would like them to be?	☐ Yes	☐ No
Do you think you have a "gummy" smile?	☐ Yes	☐ No
Are you happy with the length, width, and shape of your teeth?	☐ Yes	☐ No
Do you have any chipped teeth?	☐ Yes	☐ No
Do you have any spaces between your teeth?	☐ Yes	☐ No
Do you have any discoloration, stains, or spots on your teeth?	☐ Yes	☐ No
Would you like your teeth to be whiter?	☐ Yes	☐ No
Do you have any dental work that you don't like?	☐ Yes	☐ No
Do you have any silver fillings that you would like changed to white?	☐ Yes	☐ No
Has anyone you've known had any cosmetic dentistry done that interests you?	☐ Yes	☐ No

If there was anything else you could change about the appearance of your teeth, what would it be?

_____

_____

_____

_____

_____

Loyal DENTISTRY

624 W. Duarte Road, Suite 204
Arcadia, CA 91007
626.447.0934
www.loyaldentistry.com

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality and preventive treatment. Please understand that payment for services rendered are part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

- Full payment is due at time of service for non-insurance patients
- We accept cash, checks, Visa/Mastercard, American Express and Discover.
- If you have dental insurance, you are expected to pay your estimated portion, all copays, or deductibles at the time of service.
- We offer a no interest or extended payment plan (Care Credit) upon approved credit.
- We reserve the right to charge $50 for appointments that are missed or canceled without a 24-hour notice.
- A fee of $30 will be charged for all returned checks.

_____
(Initials)

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left towards your maximum, or how economical the treatment will be. It will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what is usual and customary, you are responsible for payment.

We will accept assignment of insurance benefits. You will be expected to pay your estimated portion of the fee for treatment. **BE AWARE THAT THIS IS ONLY AN ESTIMATE**. The actual amount could vary depending on what your insurance will cover or unexpected changes of treatment. You are ultimately responsible for any balance for services rendered. We cannot bill your insurance company unless you give us your insurance information. This information must be provided before treatment begins. Your insurance policy is a contract between your employer (or you) and your insurance company. We are not a party to that agreement. Until your insurance company has paid your portion of services rendered, the unpaid balance will show on your monthly statement.

_____
(Initials)

I have read, understand and agree to the above terms.

Print Patient Name: _____

Signature:_____Date: _____
(Patient, Parent, or Legal Guardian)