

Dr. Jay S. Grossman's & Associates' Dental Practice

Patient Registration



Dr.

Welcome to our practice! Dental care is more than repair. It is maintaining your best dental health. This is done by restoring your teeth so that they are comfortable, functional and attractive, treating your gum tissue health to last your lifetime and evaluating your general health and habits that may affect your future dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments that you might have... the more we know about your needs and concerns, the better we can serve you. Thank you!

- 1) This office practices state-of-the-art sterilization
- 2) We DO NOT discriminate

How did you find out about us? Our practice grows by referrals from our dental family. Who may we thank for referring you to our practice for your dental care?

Referral Source: _____

Date: _____ / 2008

Personal Information

Title	_____	Sex (circle one)	[Male] [Female]	Birth Date	_____
First Name	_____	Soc. Sec. #	_____		
Middle Initial	_____	Mobile Phone	_____		
Last Name	_____	Home Phone	_____		
Address	_____	Work Phone	_____		
City	_____	Email	_____		
State	_____	EmergContactName	_____		
Zip Code	_____	Contact Phone	_____		

Employer Information

Employer	_____	Phone	_____
Address	_____	Occupation	_____

Insurance Information

Insurance Company	_____	Group #	_____
Ins. Co. Address	_____	Ins. Co. Phone	_____

If Patient is not the insured	Insured's Name	_____	Soc. Sec. #	_____
	Insured's Hm Address	_____	Email	_____
		_____	Employee ID#	_____
	Insured's Wk Address	_____	Birth Date	_____
		_____	Work Phone	_____

How do you prefer to be contacted? (circle all that apply)

[Home] **[Work]** **[Mobile]** **[Email]**

1/08

Dr. Jay S. Grossman & Associates
11980 San Vicente Blvd., Suite 507
Brentwood, CA 90049
Tel. 310.820.0123 * Fax. 310.207.3784
www.drjaydds.com

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MEDICAL HISTORY

Date: / 2008

Patient Name _____

Physician Name _____

Physician Phone Number _____

Hospital or Serious Illness in Last 5 Years	Yes___ No___	Pace Maker	Yes___ No___
AIDS/Other Immunosuppressive Disorders	Yes___ No___	Women: Pregnant?	Yes___ No___
Allergies/Asthma	Yes___ No___	Due Date _____	
Arthritis, Rheumatism	Yes___ No___	Nursing?	Yes___ No___
Artificial Heart Valves	Yes___ No___	Psychiatric Care/Treatment	Yes___ No___
Artificial Joints	Yes___ No___	Radiation Treatment	Yes___ No___
Abnormal Bleeding w/ Extractions/Surgery	Yes___ No___	Rheumatic Heart Disease	Yes___ No___
Cancer	Yes___ No___	Scarlet Fever	Yes___ No___
Chemical Dependency	Yes___ No___	Sinus Trouble	Yes___ No___
Chemotherapy	Yes___ No___	STD/Venereal Disease	Yes___ No___
Diabetes	Yes___ No___	Stroke	Yes___ No___
Epilepsy Fainting or Seizures	Yes___ No___	Swollen Glands	Yes___ No___
Glaucoma	Yes___ No___	Thyroid Disorder	Yes___ No___
Headaches	Yes___ No___	Tonsillitis	Yes___ No___
Heart Murmur/Heart Disorder	Yes___ No___	Transfusion	Yes___ No___
Hepatitis	Yes___ No___	Tuberculosis	Yes___ No___
Herpes	Yes___ No___	Tumor or Growth on Neck or Head	Yes___ No___
High Blood Pressure	Yes___ No___	Ulcers	Yes___ No___
Low Blood Pressure	Yes___ No___	Unexplained Weight Loss	Yes___ No___
Kidney Disease	Yes___ No___	Have you ever taken Fen-Phen?	Yes___ No___
Any Operations in Last 5 Years?	Yes___ No___	Latex Allergy?	Yes___ No___
Liver Disease	Yes___ No___		

List any medications you are currently taking: _____

List any allergies you have: _____

Pharmacy Name _____ Pharmacy Phone _____

Date of last eye exam _____ Optometrist Name _____

To the best of my knowledge, the questions on this form have been understood by me and accurately answered. I understand that providing incorrect information can be dangerous to my health. It is MY RESPONSIBILITY to inform the dental office of any changes in my medical status. I will NOT hold my Dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____

Dentist Signature _____

Date _____

Date _____

The information documented in this form remains strictly confidential and will not be shared with third parties without the consent of the patient.



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DENTAL HISTORY

Date: / 2008

Patient Name _____ Former Dentist Name _____

Former Dentist Phone Number _____

Reason for Today's Visit _____

Date of Last Dental Visit _____ Date of Last Dental X-Rays _____

Indicate if you had or are currently aware of any of the following:

Bad Breath	Yes ___ No ___	Food Collection Between Teeth	Yes ___ No ___
Bleeding Gums	Yes ___ No ___	Grinding Teeth/Clenching	Yes ___ No ___
Blisters on Lips or Mouth	Yes ___ No ___	Gums Swollen or Tender	Yes ___ No ___
Are you missing teeth?	Yes ___ No ___	Loose Teeth or Broken Filling	Yes ___ No ___
Cigarette Smoking	Yes ___ No ___	Orthodontic Treatment	Yes ___ No ___
Clicking or Popping Jaw	Yes ___ No ___	Periodontal Treatment	Yes ___ No ___
Dentures/Partial Dentures	Yes ___ No ___	Sensitivity to Heat or Cold	Yes ___ No ___
Dry Mouth	Yes ___ No ___	Sores or Growths in Mouth	Yes ___ No ___
Finger Nail Biting	Yes ___ No ___		
Do you snore?	Yes ___ No ___		
Does your partner snore?	Yes ___ No ___		

How often do you brush? _____ Are you satisfied with the whiteness of your teeth? Yes ___ No ___
 How often do you floss? _____ Are your teeth straight enough for you? Yes ___ No ___
 Are you satisfied with your smile? Yes ___ No ___

To avoid any misunderstanding regarding your dental insurance, we wish our patients to know that **all professional services are charged directly to the patient and that patients are personally responsible for payment of fees.** We do not render services on the basis that the insurance companies will pay our fees. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made.** Our policy for missed appointments or appointments cancelled with less than 48 hours notice is as follows: \$100 or 10% of that day's scheduled treatment, whichever is higher. We appreciate the opportunity to serve you and hope you understand our implementation of cost controls such as these.

I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of medication, and therapy that may be indicated and agreed upon.

All balances over 30 days are subject to a 1.5% monthly service fee.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement. I understand that responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable, at the time services are rendered.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Updated Health History - This section is for FUTURE updates, please do not sign at this time.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

Patient Signature _____ Dentist Signature _____

Date _____ Date _____