Calabasas Smiles DENTISTRY

PATIENT INFORMATION

Today's Date____________________ ☐ **Married** ☐ **Single** ☐**Partnered** ☐**Divorced** ☐**Separated** ☐ **Widowed**

Name___________________________________ ☐ **M** ☐**F** **Birthdate**___/___/___**Age** _____ **SS#** ______________

What do you prefer to be called? ____

Home Address____

(City) (State) (Zip)

Hm #_________________________ **Cell #**_________________________**Wk #** ______________________________

Email Address____**Best time to reach you**_______________________

Whom may we thank for referring you ____

Employer____**Occupation** ______________________________

Employer's Address ____

(City) (State) (Zip)

In Case Of Emergency Contact:

Name____**Relationship**___________________________________

Emergency Home #_______________________________**Emergency Work #**_______________________________

We want to take care of your needs……

Current dental problems:_____________________________

Nervous about dental treatment**:** ☐Slightly ☐Moderately ☐Very

Dental health: ☐Excellent ☐Good ☐Fair ☐Poor

Do you avoid brushing parts of your mouth: ☐ Yes ☐ No

Sensitive to sweets/hot/cold/pressure: ☐Yes ☐ No

Interested in replacing silver (mercury) fillings: ☐Yes ☐No

Other concerns/needs:________________________

Dissatisfied with teeth / appearance: ☐Yes ☐ No

Would you like whiter teeth: ☐Yes ☐ No

Desire to close spaces in teeth: ☐Yes ☐ No

Would you like straighter teeth: ☐ Yes ☐ No

Need longer lasting solutions: ☐ Yes ☐ No

Interested in INVISALIGN : ☐ Yes ☐ No

Why did you leave your last dentist?____

Last dental appointment:____________________

AUTHORIZATIONS

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I hereby authorize Calabasas Smiles to take xrays, study models, photographs or any other diagnostic aids deemed appropriate by Calabasas Smiles to make a thorough diagnosis of my dental needs. I also authorize Calabasas Smiles to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Calabasas Smiles choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 ½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) agree to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature____________________________________ **Date**______________________

Parent or Responsible Party_________________________________ **Relationship to Patient**__________________

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