Welcome to our office

Westside Dental Associates

Les Latner, DDS (310) 477-1081

PLEASE
PRINT
CLEARLY

[ ] MARRIED [ ] SINGLE
[ ] MALE [ ] FEMALE

NAME _____
LAST NAME FIRST NAME MIDDLE

ADDRESS _____

CITY, STATE ZIP _____

BIRTH DATE _____ SS# _____ DRIVERS LIC # _____

PHONE NUMBERS: HOME ( ) _____ WORK ( ) _____

CELL( ) _____ E-MAIL _____

PLACE OF EMPLOYMENT _____

ADDRESS, CITY, STATE ZIP _____

Who may we thank for referring you to us? _____

RESPONSIBLE PARTY

Self: STUDENT? [ ] F/T [ ] P/T SCHOOL _____

NAME _____
LAST NAME FIRST NAME MIDDLE

ADDRESS _____

CITY, STATE ZIP _____

PHONE #: HOME _____ WORK _____

BIRTH DATE _____ SS# _____

EMPLOYER _____

DENTAL INSURANCE CO _____

GROUP / POLICY # _____

PHONE # ( ) _____

Spouse or Parent:

NAME _____

ADDRESS _____

CITY, STATE ZIP _____

PHONE #: HOME _____ WORK _____

BIRTH DATE _____ SS# _____

EMPLOYER _____

DENTAL INSURANCE CO _____

GROUP / POLICY # _____

PHONE # ( ) _____

IN CASE OF EMERGENCY:

NAME _____

ADDRESS _____

CITY, STATE ZIP _____

PHONE # _____

MY PREFERRED METHOD OF PAYMENT IS

[ ] CASH OR CHECK

[ ] CREDIT CARD

[ ] MONTHLY FINANCING

I understand and accept responsibility for all dental services provided.

_____
SIGNATURE DATE

HEALTH HISTORY

PATIENT'S NAME _____ BIRTH DATE _____

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE ( ) _____

PHYSICIAN'S ADDRESS _____ CITY _____ ZIP _____

MEDICAL

Circle Yes or No

Yes No 1. Are you in good health?
Yes No 2. Has there been any change in your general health with the past year?
Yes No 3. Are you now under the care of a physician?
If so what is the condition being treated?_____
Yes No 4. Have you ever had any serious illness, operation, or hospitalization? _____
Yes No 5. Are you taking any drugs or medicine? (including recreational drugs)
If so what and what dosage? _____
Yes No 6. Have you ever been premedicated with antibiotics for heart problems for your dental treatment?
Yes No 7. Are you sensitive or allergic to any of the follow: ☐ Penicillin; ☐ Sulfa; ☐ Tetracycline; ☐ Latex
☐ Codeine or other narcotic; ☐ Aspirin; ☐ Erythromycin; ☐ Other
8. Do you have, or have you had any of the following:

☐ Heart Murmur	☐ High Blood Pressure	☐ Sinus Trouble	☐ Drug Addiction	☐ Tumors or Growths
☐ Heart Failure	☐ Scarlet Fever	☐ Emphysema	☐ Mental/Nervous Disorder	☐ Chemotherapy (Cancer)
☐ Heart Attack	☐ Bruise Easily	☐ Hay Fever	☐ Epilepsy or Seizures	☐ Radiation Treatment
☐ Heart Surgery	☐ Excessive Bleeding	☐ Asthma	☐ Fainting Spells	☐ Hearing Impaired
☐ Angina Pectoris	☐ Hemophilia	☐ Tuberculosis (T.B.)	☐ Headaches/Migraines	☐ Other_____
☐ Congenital Heart Lesions	☐ Blood Disease	☐ Diabetes	☐ Stomach Ulcers	_____
☐ Rheumatic Fever	☐ Thyroid Disease	☐ Arthritis	☐ Joint Replacement	_____
☐ Pacemaker	☐ Kidney Disease	☐ Cold Sores/Herpes	☐ HIV Positive / Aids	_____
☐ Stroke	☐ Liver Disease/Hepatitis		☐ Venereal Disease	_____

Yes No 9. Do you smoke tobacco? If yes, how much? _____ per day
Yes No 10. Do you have any disease or condition or problem not listed above that you think I should know about?
If so, what? _____
Yes No 11. (Women) is there a possibility you may be pregnant?
Yes No 12. (Women) Do you take birth control pills or patch?

DENTAL

Circle Yes or No

1. Previous Dentist_____City _____
Yes No 2. Have you been having any specific problem?
Explain_____
Yes No 3. Does your dental treatment make your nervous?
If so, check one: ☐ slightly ☐ moderately ☐ severely

Yes No 4. Do you have, or have you had any of the following:

☐ Bad Breath		☐ Loosening of Teeth	☐ Sensitive Teeth
☐ Receding Gums		☐ Cold Sores	. . . to ☐ Sweets or ☐ Temperature
☐ TMJ (Temporomandibilar joint) Disorder		☐ Headaches	☐ Bleeding Gums
☐ Pain in Jaw Joints			☐ Difficulty Swallowing
☐ Grind you Teeth . . .at	☐ Night or	☐ Day	
☐ Clench your Teeth . . .at	☐ Night or	☐ Day	
☐ Jaws . . . ☐ Pop ☐ Lock ☐ Hurt			

Yes No 5. Have you ever had any of the following? ☐ Injury ☐ Oral Surgery ☐ Orthodontics ☐ Periodontics
Explain _____
Yes No 6. Have you ever had any unfavorable reaction from a local anesthetic?
7. How long since your last dental treatment? _____
8. How long since your last dental x-rays?_____
Yes No 9. Would you desire to be pre-sedated? ☐ Nitrous Oxide ☐ Drugs_____☐ Or_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

DATE_____ PATIENT, PARENT/GUARDIAN SIGNATURE_____

DATE_____ DENTIST SIGNATURE _____

DATE_____ RDH SIGNATURE _____