PATIENT INFORMATION SHEET

Patient Name _____ DOB _____ SSN _____ ☐Female ☐Male

Address_____
(Street) (City) (Zip)

Home Phone_____ Cell Phone _____ Email_____

I preferred to be contacted by (select all that apply): ☐Mail ☐Home Phone ☐Cell Phone ☐Text Msg (carrier charges may apply) ☐Email

Employer_____ Occupation _____ Phone_____

Address_____
(Street) (City) (Zip)

Emergency Contact Name_____ Phone _____ Relationship_____

Primary Care Physician_____ Phone_____ ☐No Physician

Address_____
(Street) (City) (Zip)

Previous Dentist_____ Phone_____ ☐No previous dentist

Address_____
(Street) (City) (Zip)

Whom may we thank for referring you? _____

Person responsible for this account ☐ Patient ☐Other_____Relationship_____

Primary Insurance Company_____

Insured Name_____ Group Number_____ Member Number_____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be predetermined.

All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for in full at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that the Pasadena Dental Group will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, the Pasadena Dental Group cannot render services on the assumption that charges will be paid by any insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1.5% per month (18% per annum) may be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date.

In consideration of the professional services rendered to me by Dr. Mizuno and/or his staff, I agree to pay the reasonable value of said services to Dr. Mizuno or his assignee at the time services are rendered, or within five (5) days of billing if credit shall be extended. Additionally, I agree that in the event that either the Pasadena Dental Group or I initiate any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

Should a dispute arise between the patient (or patient representative) and the Pasadena Dental Group or any of its doctors or staff, arbitration will be used as the sole form of dispute resolution. The laws of the state of California shall apply, and an impartial arbitrator shall be selected based on mutual agreement.

I understand that in an effort to maintain an environmentally friendly office, most forms and documents (including Privacy Practices) are available to me online at the Pasadena Dental Group's website located at www.pasadenadentalgroup.com. Paper copies are available upon request only.

These terms and conditions are subject to change from time to time. The most current and valid version will be made available online.

My signature below indicates I have read the above terms and conditions of treatment and agree to their content.

Signed_____ Date_____

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.

MEDICAL HISTORY

1. Are you in good health?..... ☐**Yes** ☐**No**
2. Date of last physical exam _____ Are you now under the care of a physician?..... ☐**Yes** ☐**No**
   If yes, what is the condition being treated?_____
3. Have you ever had any serious illness or operation?..... ☐**Yes** ☐**No**
   If yes, what illness or operation?_____
4. Have you ever been hospitalized?..... ☐**Yes** ☐**No**
   If yes, what was the problem?_____
5. Are you currently taking any ☐medications, ☐drugs, ☐herbal supplements?..... ☐**Yes** ☐**No**
   If yes, what?_____ What dosage?_____
6. Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If yes, what? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment?..... ☐**Yes** ☐**No**
8. Are you sensitive or allergic to ☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Latex ☐Other_____ ☐**None known**
9. Do you have or have you had any of the following: (Select Y for Yes and N for No. Answer all conditions)

☐**Y**☐**N** Anemia	☐**Y**☐**N** Implant(s)	☐**Y**☐**N** Head Injuries	☐**Y**☐**N** Drug Addiction	☐**Y**☐**N** Blood Transfusion	☐**Y**☐**N** Excessive Bleeding	☐**Y**☐**N** X-Ray or Cobalt Treatment
☐**Y**☐**N** Herpes	☐**Y**☐**N** Headaches	☐**Y**☐**N** Heart Failure	☐**Y**☐**N** Kidney Disease	☐**Y**☐**N** Joint Replacement	☐**Y**☐**N** Mitral Valve Prolapse	☐**Y**☐**N** Radiation Treatment
☐**Y**☐**N** Stroke	☐**Y**☐**N** Glaucoma	☐**Y**☐**N** Scarlet Fever	☐**Y**☐**N** Chemotherapy	☐**Y**☐**N** Nervous Disorder	☐**Y**☐**N** High Blood Pressure	☐**Y**☐**N** Venereal Disease
☐**Y**☐**N** Ulcers	☐**Y**☐**N** Tonsillitis	☐**Y**☐**N** Sinus Trouble	☐**Y**☐**N** Stomach Ulcers	☐**Y**☐**N** Tumors or Growths	☐**Y**☐**N** HIV Related Complex	☐**Y**☐**N** HIV/AIDS
☐**Y**☐**N** Diabetes	☐**Y**☐**N** Hemophilia	☐**Y**☐**N** Heart Murmur	☐**Y**☐**N** Angina Pectoris	☐**Y**☐**N** Allergies or Hives	☐**Y**☐**N** Respiratory Disease	☐**Y**☐**N** TMJ Disorder
☐**Y**☐**N** Arthritis	☐**Y**☐**N** Cold Sores	☐**Y**☐**N** Liver Disease	☐**Y**☐**N** Mental Disorder	☐**Y**☐**N** Pain in Jaw Joints	☐**Y**☐**N** Epilepsy or Seizures	☐**Y**☐**N** Other:
☐**Y**☐**N** Asthma	☐**Y**☐**N** Emphysema	☐**Y**☐**N** Blood Disease	☐**Y**☐**N** Thyroid Disease	☐**Y**☐**N** Artificial Prosthesis	☐**Y**☐**N** Psychiatric Treatment	
☐**Y**☐**N** Cancer	☐**Y**☐**N** Rheumatism	☐**Y**☐**N** Heart Ailments	☐**Y**☐**N** Fainting Spells	☐**Y**☐**N** Sickle Cell Disease	☐**Y**☐**N** Hepatitis or Jaundice	
☐**Y**☐**N** Seizures	☐**Y**☐**N** Chicken Pox	☐**Y**☐**N** Heart Attack	☐**Y**☐**N** Rheumatic Fever	☐**Y**☐**N** Cortisone Medicine	☐**Y**☐**N** Difficulty Swallowing	
☐**Y**☐**N** Hay Fever	☐**Y**☐**N** Bruise Easily	☐**Y**☐**N** Cerebral Palsy	☐**Y**☐**N** Tuberculosis (TB)	☐**Y**☐**N** Allergies to Metals	☐**Y**☐**N** Congenital Heart Lesions	

10. Do you have any disease, condition or problem not listed that you think we should know about?..... ☐**Yes** ☐**No**
    If yes, what?_____
11. Do you wear a cardiac pacemaker, or have you ever had heart surgery?..... ☐**Yes** ☐**No**
12. Do you smoke ☐Cigarettes ☐Cigars ____Packs per day..... ☐**Yes** ☐**No**
13. Have you ever taken the drugs ☐Fen-Phen ☐Redux or any ☐diet drugs?..... ☐**Yes** ☐**No**
14. (Women) Are you pregnant? ☐ No ☐ Yes, _____ months
15. (Women) Do you have problems associated with your menstrual period?..... ☐**Yes** ☐**No**
16. (Women) Do you take any birth control medication or hormones?..... ☐**Yes** ☐**No**

DENTAL HISTORY

1. Have you ever had local anesthetic (novocaine, etc.)?..... ☐**Yes** ☐**No**
2. Have you ever had any unfavorable reaction from a local anesthetic?..... ☐**Yes** ☐**No**
3. Have you ever had any serious trouble associated with any previous dental treatment?..... ☐**Yes** ☐**No**
   If yes, please explain_____
4. How long since your last full mouth X-Rays? _____ Weeks _____Months _____Years
5. How long since your last dental treatment? _____ Weeks _____Months _____Years
6. Do dental treatments make you nervous? ☐Slightly ☐Moderately ☐ Extremely..... ☐**Yes** ☐**No**

☐ I hereby acknowledge that I have received a copy of the **Notice of Privacy Practices** as posted on the practice website. I further understand that the Pasadena Dental Group will offer me updates to this Notice of Privacy Practices via their website should it be amended, modified or changed in any way. ☐ Patient refused/I was unable to sign because_____

☐ I hereby acknowledge that I have received an electronic or paper copy of the **Dental Materials Fact Sheet** as required by law.

Signature_____ Date_____ Reviewed by _____ Date_____

Update – since your last visit:

1. Have you seen a medical doctor?..... ☐**Yes** ☐**No**
2. Have you had a change in your medication?..... ☐**Yes** ☐**No**
3. Have you had change in your medical condition or had surgery?..... ☐**Yes** ☐**No**

Please note changes in health since last visit. If no changes, please write "None"

Reviewed By:
_____Date_____
Notes:

Signature _____ Date _____

Update – since your last visit:

1. Have you seen a medical doctor?..... ☐**Yes** ☐**No**
2. Have you had a change in your medication?..... ☐**Yes** ☐**No**
3. Have you had change in your medical condition or had surgery?..... ☐**Yes** ☐**No**

Please note changes in health since last visit. If no changes, please write "None"

Reviewed By:
_____Date_____
Notes:

Signature _____ Date _____

CONSENT FOR TREATEMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient named on this form to administer such anesthetics, analgesics and sedatives; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. ***All services are rendered and accepted under the terms and conditions printed on the reverse.***

Authorization must be signed by the patient or legal guardian in the case of a minor or when the patient is physically or mentally incompetent.

Signature_____ Date_____ Relationship to Patient_____