**Mint Dental OC**
16963 Imperial Hwy, Yorba Linda, CA 92886
Phone (714) 577-0980 ● Fax (855) 299-4988
www.mintdentaloc.com

## Patient Information

Patient Name: _____, _____ _____ Date:_____
Last First Middle Initial

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ - _____ - _____ Birth Date: _____/_____/_____
MM DD YYYY

Phone - Home : (_____)_____ Work : (_____)_____ Ext:_____

Cell : (_____)_____ Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Email

E-mail: _____ DL#: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

## Responsible Party Information

Person responsible for payments and/or insurance: ☐ self ☐ spouse ☐ parents

Name: _____ ☐ Male ☐ Female

Social Security #: _____ - _____ - _____ Birth Date: _____/_____/_____

Phone (Home): _____ (Work): _____ Ext:_____

## Medical Health History

Have you ever had any of the following? Mark **ALL** that apply. **IF NONE, please mark appropriate box below.**

- ☐ AIDS
- ☐ Allergy to Latex
- ☐ Allergy to Penicillin
- ☐ Allergy to Codeine
- ☐ Anemia
- ☐ Antiresorptive Agent (i.e. Fosamax,Actonel,Boniva)
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer specify: _____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Joint Replacement Date: _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Prosthetic Heart Valve
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors specify: _____
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:

- ☐ _____

☐ **NO known medical problems OR allergies as of this date: _____**

Are you currently taking any medications? If yes, please list: _____

_____

## Dental Health History

Date of LAST Dental Visit: _____ Reason: _____

| | Yes | No | Unsure |
|---|---|---|---|
| Do your gums bleed when you brush or floss ? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure ? | ☐ | ☐ | ☐ |
| Do you experience dry mouth often ? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments ? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment ? | ☐ | ☐ | ☐ |
| Do you have earaches or neck pains ? | ☐ | ☐ | ☐ |
| Do you have any clicking, popping or discomfort in the jaw ? | ☐ | ☐ | ☐ |
| Do you brux or grind your teeth ? | ☐ | ☐ | ☐ |
| Do you get sores or ulcers in your mouth often ? | ☐ | ☐ | ☐ |

How do you feel about your smile? _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain:_____

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain:_____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain:_____

- **Emergency Contact**: _____ **Relation**: _____

  **Phone Number**: _____

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

_____ Date: _____

Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to our practice? ☐ Family/Relative ☐ Friend ☐ Co-worker

☐ Google ☐ Yelp ☐ Facebook ☐ Walk-In ☐ Other, explain:_____

Name of person or office referring you to our practice: _____

# Consent for Services

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

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party