Mirage Lane Dentistry
Family & Cosmetic Dentistry
(760) 341-4515

Patient Information

Date _____

Patient's Name _____ Social Security # _____

Date of Birth _____ Age _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Street _____ City _____ State_____ Zip_____

Home Phone _____ Cell _____ E-mail _____

Employer_____ Occupation _____ Work Phone _____

Spouse Name _____ Employer _____ Date of Birth _____

Spouse Social Security #_____ Date of Birth _____
(only if spouse is the subscriber on your insurance)

Person to contact in case of emergency _____ Phone number_____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber's Name_____ Dental Insurance Company _____ Policy ID # _____

Is patient covered by secondary insurance Yes/No

Secondary Dental Insurance Company _____ Employer _____ Policy ID # _____

Dental History

Purpose of Visit _____ Former Dentist_____ Date of last dental visit_____

How often do you floss? (___) Times a day. How often do you brush? (___) Times a day.

Have you ever had any complications following dental treatment? Yes/No If yes please describe _____

Have you ever had a local anesthetic (Novocaine, etc,) Yes/No Did you have any unfavorable reaction from the local

Anesthetic? If yes please explain? _____

Have you had any serious trouble associated with any previous dental treatment? Yes/No if yes please explain?

_____

Please circle Y for yes or N for no of the following which apply to you now or in the past, if none apply, please check here ☐

Y N Bad Breath
Y N Bleeding Gums
Y N Blisters or lips (mouth)
Y N Cigarette, pipe, or cigar smoke
Y N Clicking or popping in Jaw
Y N Dry Mouth
Y N Food Collection between teeth
Y N Foreign Objects
Y N Grinding Teeth
Y N History of Periodontal Disease
Y N Loose Teeth or broken fillings
Y N Orthodontic Treatment
Y N Sensitivity to temperature
Y N Sores or growths in mouth

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Medical History

These questions are for your benefit and assure that the 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, Check the appropriate box and /or circle Yes or No where applicable.

1. Are you in good health? Yes No
2. Date of last physical examination: Date: _____
3. Are you under the care of a physician? **Name of Physician**: _____ Phone #:_____ Yes No
4. Have you ever had any serious illness or operation? Yes No
   If so what illness or operation: _____
5. Have you ever been hospitalized? Yes No
   If so what was the problem: _____
6. Are you taking any ☐ medications, ☐ drugs or ☐ herbs? Yes No
   If so, what? _____ What Dosage?_____
7. Are you using any recreational drugs (marijuana, cocaine, ect?) If so, What? _____ Yes No
8. Have you ever been pre-medicated with antibiotics for your dental treatment? Yes No
9. Are you sensitive or **allergic** to any drugs or materials:
   ☐ Penicillin; ☐Tetracycline; ☐Aspirin; ☐ Sulfa Drugs; ☐Codeine; ☐Latex; ☐ Other _____ Yes No
   If other, what drug? _____
10. Do you have or have you had any of the following: (**Please circle all that apply to all conditions if none check here**) ☐

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

11. Do you have any disease, condition or problem not listed that you can think we should know about? Yes No
    If so what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? Yes No
13. Do you smoke? If yes, how much? _____ ☐ Cigarettes; ☐ Cigar; ☐ Packs per day _____ Yes No
14. Have you ever taken the drugs ☐ Fen-Phen; ☐ Fosamax (**Bisphosphonate**), ☐ Boniva; or any Diet Drugs Yes No
15. (women) Are you pregnant? If so how many months? _____ Yes No
16. (Women) Do you have any problems associated with your menstrual period? Yes No
17. (Women) Do you take any birth control medication or hormones? Yes No

Acknowledgement of Notice of Privacy Practices: *Please Initial*

I hereby acknowledge I have received a copy of the practice's privacy notice. _____

I hereby acknowledge I have received a copy of the Dental Materials Fact Sheet: _____

Date: _____ Signature: _____ Reviewed by: _____ Lic#:_____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor the patient is physically or mentally incompetent.
Consent for treatment: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form to administer such anesthetics, analgesics, 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. ***Please Initial*** _____

Patient/Guardian Signature _____ **Date:** _____

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OFFICE POLICY

Welcome to Mirage Lane Dentistry!!

Thank you for choosing us to provide you with the utmost professional and friendly dental care. Here at Mirage Lane Dentistry we are growing and improving every day! Therefore, we would like to inform you of our office policies to ensure equality amongst our patients.

We kindly ask that you give us **24 HOURS NOTICE**, should you cancel your scheduled appointment. If not**, we reserve the right to charge $65 for the time reserved**. We may also refer you out, should this occur more than 3 times. If an urgent situation should occur, please inform us as soon as possible. This enables us to schedule other patients to come in, who have been waiting for earlier time slots or readily available care.
This schedule is especially made for your dental needs, so we ask for your cooperation in giving you the best possible treatment.

***Payment is expected when services are rendered, unless other arrangements are made in advance. If other arrangements have not been made, we reserve the right to charge overdue balances with monthly interest.**

I agree and understand the policy as stated:

x_____

PHOTO RELEASE

I grant Mirage Lane Dentistry, the right to take photographs of me and my smile.
"Mirage Lane Dentistry will not use any photo for advertisement or promotion"

We look forward to a great beginning of a happy and healthier smile!!

Sincerely,

Mirage Lane Dentistry

I agree and understand the policy as stated:

x_____

How would you like to be contacted?

Phone call to Cell Number and or Text Messages
Cell Number: _____
E-Mail: _____