La Jolla Smile Design
Robert Y. Takano, DDS, Inc
8910 University Center Lane, Suite 670

Patient Information

Patient Name: _____ Date_____
Last First MI (Preferred Name)

E-Mail: _____Gender: ____Family Status: ____

Social Security_____ Birth Date: _____

Phone (Home_____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

1. Do you think that your teeth are affecting your general health? ---------- ☐Yes ☐ No
2. Are you dissatisfied with the appearance of your teeth? ---------- ☐Yes ☐ No
3. Are you interested in having braces or Invisialign? ---------- ☐Yes ☐ No
4. Are you worried about receiving dental treatment or have you ever fainted? ---------- ☐Yes ☐ No
5. Do you have difficulty chewing your food or opening your mouth wide? ---------- ☐Yes ☐ No
6. Do you have sensitive teeth, bleeding gums or sore gums? ---------- ☐Yes ☐ No
7. Do you ever have canker sores, cold sores or a sore mouth? ---------- ☐Yes ☐ No
8. Have you ever had an injury to your face or jaws? ---------- ☐Yes ☐ No
9. Are you currently taking any prescription medications? (Please list) ---------- ☐Yes ☐ No
   _____
10. Have you ever experienced an unusual reaction to a dental anesthetic? ---------- ☐Yes ☐ No
11. Have you ever experienced an unusual reaction to any of the following drugs? (Please circle)
    Aspirin, Penicillin, Iodine, Sulfa drugs, other medications
12. Have you ever been treated for alcohol or drug dependency or do you use tobacco? ---------- ☐Yes ☐ No
13. Have you been examined by a physician within the last year? ---------- ☐Yes ☐ No
14. Is a physician treating you at the present time? ---------- ☐Yes ☐ No
15. Have you ever been seriously ill, hospitalized or had surgery? ---------- ☐Yes ☐ No
16. Have you ever had a blood transfusion? ---------- ☐Yes ☐ No
17. Have you ever radium or cobalt treatments? ---------- ☐Yes ☐ No
18. Have you ever been treated for a growth, tumor, cancer, malignancy or any other
    Similar condition? ---------- ☐Yes ☐ No
19. Do you have any reason to believe that you have been exposed to HIV/AIDS? ---------- ☐Yes ☐ No
20. Have you ever had an artificial joint, pin, plate or other device surgically implanted? ---------- ☐Yes ☐ No
21. Have you ever had any of the following diseases? (Please circle) Rheumatic Fever, Kidney Disease,
    Hepatitis, Liver Disease, Tuberculosis, Venereal Disease, Heart Attack, Stroke, Bleeding Disorder,
    Stomach Ulcers, Epilepsy, Diabetes, High Blood Pressure, Mononucleosis, Depression/Anxiety,
    Eating Disorder, Intestinal Disorder, or any other disease.
22. Do you have a pacemaker? ---------- ☐Yes ☐ No
23. Have you ever had any heart valve disorders? ---------- ☐Yes ☐ No
24. Have you ever been told by a physician that you have a heart murmur? ---------- ☐Yes ☐ No
25. Has there been any change in your general health recently? ---------- ☐Yes ☐ No
26. Do you bleed for a long time when cut? ---------- ☐Yes ☐ No
27. Do you have frequent colds, sore throats or nosebleeds? ---------- ☐Yes ☐ No
28. Has your appetite changed or have you had an unexplainable change in weight? ---------- ☐Yes ☐ No
29. Do you have excessive thirst or urinate with unusual frequency? ---------- ☐Yes ☐ No
30. Do you have asthma, hay fever, hives, itchiness, skin rash or respiratory allergies? ---------- ☐Yes ☐ No
31. Do you have a chronic cough or do you ever cough up blood? ---------- ☐Yes ☐ No
32. Do you ever have chest pain, difficulty climbing two flights of stairs, or swelling of the ankles? -------- ☐Yes ☐ No
33. Females – Are you pregnant? ---------- ☐Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

☐ Dental Office ☐ Church Bulletin ☐ Insurance ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice_____

Spouse or Responsible Party Information

The following is for ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

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 Phone

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

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.

I understand that if a local anesthetic is required, there may be temporary and sometimes permanent loss of sensation and muscle function following injections.

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 90 days 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 have read the above conditions of treatment and payment and agree to their content. Office policy will charge $65/hr for missed appointments. I have received a copy of the Dental Materials Fact Sheet as required by law.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party