Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing our practice. It is our goal to assist you with all of your dental needs.

The focal point of our practice is to provide total comprehensive dental care to the whole family in a caring, gentle and friendly environment. We encourage you to ask any question you may have regarding your treatment options. Procedures performed in our office consist, but are not limited to preventive care, restoration of teeth, crowns, dental implants, root canal treatments, extractions, and esthetic procedures.

Office information and policy

Hours

- Monday, Tuesday, Thursday and Friday from 8:00 am to 5:00 pm
- Saturday from 9:00 am to 3:00 pm
- We are CLOSED on Wednesdays

Appointments

Everyone is reserved individual time for their visit with the doctor or hygienist and we strive to remain on schedule. If you are delayed or cannot make your appointment, please contact our office immediately. Twenty-four hour notice is required to change a reserved time with our office.

Payment Plans

We offer financial payment plans (Care Credit and other individual plans). Ask us!

Visit our website at www.sunsetdentalplace.com to get to know us better.

We look forward to be able to serve you, and again, welcome to our practice.

Signature _____ Date _____

Patient Information

Name: _____ Sex: _____
Last First M

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____
Street Apt # City State Zip

Phone: H_____ W_____ C _____ E-mail_____

Birth date: _____ Age: _____ Social Security #: _____

Occupation: _____ Employer: _____

Driver's License # _____ Dental Insurance Co.: _____

Who may we thank for referring you to our office? _____

Family Information

Spouse's name: _____ Phone #: _____

If child, Mother's name: _____ Phone #: _____

If child, Father's name: _____ Phone #: _____

Person financially responsible: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

Personal Privacy Statement

ALL MEDICAL, DENTAL AND PERSONAL INFORMATION LISTED HERE IS STRICTLY CONFIDENTIAL AND SOLELY FOR THE PURPOSE OF PROVIDING OPTIMAL DENTAL CARE. THIS INFORMATION MAY BE SHARED WITH OTHER HIPPA COMPLIANT HEALTH CARE PROFESSIONALS AND/OR INSURANCE CARRIERS WHEN DEEMED APPROPRIATE.

I authorize Sunset Dental Place to examine and take X-rays, study casts, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize Sunset Dental Place to provide any and all forms of treatment, medication and therapy indicated. I understand that the use of anesthetic embodies certain risks. I consent to the taking of photographs not showing my face before, during and after treatment, and to the use of any of the above by the doctor in scientific papers or demonstrations. I fully accept all financial responsibility for treatment rendered by Sunset Dental Place and will pay all costs associated with collection.

I certify that I have read or had read to me the contents of this form. To my knowledge, all answers are true and complete. I agree to keep Sunset Dental Place updated as to any changes in medications or any part of my medical history. I will not hold my dentist, or any other member of their staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date_____

Medical History

Are you currently under a physician's care? ..... Y N

If so, what condition is being treated? _____

Physician names and Phone # _____

_____

Any serious illness/ hospitalization? ..... Y N

Are you presently taking any drugs, including non-prescription medications?..... Y N

If so, please specify:_____

_____

_____

Any allergies or reactions to:

- Penicillin or other antibiotics? ..... Y N
- Codeine or other narcotics?..... Y N
- Local anesthetics?..... Y N
- Aspirin?..... Y N
- Metals? ..... Y N
- Latex?..... Y N

Are you pregnant or nursing a child?..... Y N

Any difficulty breathing or shortness of breath upon exertion?..... Y N

Asthma, hay fever or sinus trouble?..... Y N

Tuberculosis, emphysema, bronchitis or other respiratory problems?..... Y N

Rheumatic fever or heart murmur (Mitral Valve Prolapse)?..... Y N

Heart disease?..... Y N

Blood pressure problems? ..... Y N

Do your ankles swell? ..... Y N

Arthritis or painful, swollen joints?..... Y N

Any artificial joints, hips or other prostheses?..... Y N

Cancer?..... Y N

Radiation or chemotherapy?..... Y N

Diabetes? ..... Y N

Stomach ulcers or esophageal reflux? ..... Y N

Hepatitis, jaundice or liver disease? ..... Y N

Thyroid problems? ..... Y N

Kidney trouble? ..... Y N

Fainting spells, dizziness or seizures? ..... Y N

History of nervous disorders or mental health issues? ..... Y N

Bleeding or clotting problems? ..... Y N

Anemia?..... Y N

Bruise easily? ..... Y N

Venereal disease, herpes or other sexually transmitted disease?..... Y N

HIV positive or any problems of the immune system? ..... Y N

Do you smoke? Y N How much per week/ Packs per day?_____

Please note any other medical condition not listed above:

Dental History

Please describe the primary reason for your visit (concerns):

1. _____
2. _____
3. _____

What is most important for you as it relates to your dental health?

_____

_____

If you could rate your smile from 1-10, what would it be? _____

Would you like to improve your smile? Y N How? _____

_____

Have you ever experienced or been told you have any of the following?

___ Bad breath
___ Unpleasant taste
___ Dry mouth
___ Food impaction
___ Cheek or lip biting
___ Clenching or grinding
___ Pain around ear
___ Jaw problems (TMD)
___ Facial pain or trauma
___ Dental pain
___ Bleeding gums
___ Periodontal treatment
___ Orthodontic treatment
___ Root canal treatment
___ Frequent blisters
___ Difficulty chewing food
___ Sensitive to eating sweets
___ Malocclusion
___ Difficulty opening wide
___ Sensitive to cold/ heat
___ Swelling or lumps in the mouth
___ Burning sensation in mouth
___ Removable partials/ dentures
___ Unfavorable dental experience
___ Stained or discolored teeth
___ Complications from extractions
___ Clicking or popping near the ear
___ Tension headaches/ migraines
___ Missing or loose teeth
___ Shift or change in bite

DOCTOR'S NOTES: _____

_____

_____

_____

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