MISSION DENTAL ARTS

MARGARET D. ALMAJANO DMD, INC.
LA PAZ MEDICAL CENTER
26302 LA PAZ ROAD, SUITE 109
MISSION VIEJO, CA 92691

PATIENT INFORMATION

Date _____ ID#SS# _____

Patient _____

Address _____

_____
City State Zip

Sex F ☐ M ☐ Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone ( ) _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co _____

Group# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Dr. _____ all insurance benefits if any otherwise payable to me for services rendered. I understand that I an financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release al information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____
Responsible Party Signature

_____
Relationship Date

PHONE NUMBER

Home _____ Work _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household) _____

Name _____ **Relationship** _____

Home Phone _____ **Work Phone** _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last cental X-rays _____

Place a mark on "yes or "no to indicate if you have had any of the following.

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____