POMERADO COSMETIC DENTISTRY

Valeri Sacknoff, D.D.S. **W. Robbi Wilson, D.D. S.**

15725 Pomerado Rd., Suite 110, Poway, CA 92064 tel: 858.485.6900 fax: 858.485.5875

Patient Information

☐ Mr ☐ Mrs. ☐ Ms. ☐ Dr First Name _____ M.I. Last Name _____ Preferred Name _____

Sex ☐ Male ☐ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Home Tel (____) _____ Cell (____) _____ Referred By _____

Previous Dentist _____ Medical Doctor _____ Tel (____) _____

Nearest relative not living with you _____ Tel (____) _____

Employer _____ Tel (____) _____

In case of emergency, please contact _____ Tel (_____) Relation _____

Spouse or orher guarantor information (if different from above)

Name _____ Relation _____ S.S.# _____ Birth Date _____

Address _____ City _____ State Zip _____

Tel. (____) _____ Employer _____ Bus. Tel. (_____

INSURANCE INFORMATION

Flex Spending Account or Heath Savings Account: yes ☐ no ☐

Student:	☐ Full Time	☐ Part Time	☐ N/A	School Name: _____		
Status:	☐ Married	☐ Divorced	☐ Widow	☐ Legally Separated	☐ Single	☐ Partner
Employed:	☐ Full Time	☐ Part Time	☐ Retired	☐ Self -Employed	☐ N/A	

PRIMARY INSURANCE COMPANY

Insurance Type: ☐ **Dental** **Plan Name:** _____

Employer _____

Address _____

Tel (___) _____

Insurance Company _____

Address _____

Tel (____) _____

Group # _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Address (of insured party) _____

City, State, Zip _____

Tel (____) S.S.# _____

Dental I.D.# _____

SECONDARY INSURANCE COMPANY

Insurance Type: ☐ **Dental** **Plan Name:** _____

Employer _____

Address _____

Tel (___) _____

Insurance Company _____

Address _____

Tel (____) _____

Group # _____

Insured Party _____ Relation _____

Sex: ☐ M ☐ F Birth Date _____

Address (of insured party) _____

City, State, Zip _____

Tel (____) S.S.# _____

Dental I.D.# _____

DENTAL INFORMATION

Reason for today's visit: Are you in pain? ☐ No ☐ Yes, for how long? _____

Please indicate any of the following problems by checking off the corresponding box:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Discomfort, clicking, or popping in jaw	☐	☐	Lost / broken filling(s)	☐	☐	Stained teeth	☐	☐	Difficulty closing jaw
☐	☐	Red, swollen, or bleeding gums	☐	☐	Teeth grinding / clenching	☐	☐	Locking jaw	☐	☐	Difficulty opening jaw
☐	☐	A removable dental appliance	☐	☐	Ringing in ears	☐	☐	Bad breath	☐	☐	Loose / shifting teeth
☐	☐	Blisters / sores in or around the mouth	☐	☐	Broken / chipped tooth	☐	☐	Burning tongue / lips	☐	☐	Food caught between teeth
☐	☐	Prolonged bleeding from an injury / extraction	☐	☐	Gum disease	☐	☐	Toothache	☐	☐	Swelling / lumps in mouth
☐	☐	Recent infections or sore throat	☐ Other:								
☐	☐	My teeth are sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting									

Last dental exam _____ Last dental x-rays _____ How many times a day do you brush? _____ Floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

Would you like whiter teeth? ☐ Yes ☐ No

Appliances worn at night ☐ Niteguard ☐ Invisilign ☐ Ortho Retainer ☐ Bleaching Trays ☐ Cpap ☐ Snoreguard

MEDICAL HISTORY

Are you in good health? ☐Yes ☐No Are you under the care of a physician? ☐ Yes ☐ No Physician's Name: _____

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No Please list: _____

Do you have, or have you had, any of hte following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Mitral valve prolapse	☐	☐	Blood disorder	☐	☐	Do you use chewing tobacco	☐	☐	Dementia
☐	☐	Heart murmur	☐	☐	Abnormal bleeding	☐	☐	Do you smoke	☐	☐	Fainting spells
☐	☐	High blood pressure	☐	☐	Anemia	☐	☐	Radiation/Chemotherapy	☐	☐	Convulsions/Epilepsy
☐	☐	Low blood pressure	☐	☐	Hemophilia	☐	☐	Low blood sugar	☐	☐	Headaches
☐	☐	Chest pain/Angina	☐	☐	Bronchitis/Chronic cough	☐	☐	Kidney trouble	☐	☐	Alzhelmer's
☐	☐	Heart attack(s) Date:	☐	☐	Asthma	☐	☐	Are you on dialysis	☐	☐	Mental health problems
☐	☐	Irregular heartbeat	☐	☐	Inhaler Carried	☐	☐	Delay in healing	☐	☐	Thyroid trouble hypo or hyper
☐	☐	Cardiac pacemaker (shielded)	☐	☐	Do you snore	☐	☐	Diabetes Type I or II	☐	☐	Arthritis/Joint disease
☐	☐	Heart surgery Type:	☐	☐	Sleep Apnea	☐	☐	Cortisone treatments	☐	☐	Osteoporosis/Osteopenia
☐	☐	Chronic fatigue/Night sweat	☐	☐	Previous Sleep Test Date:	☐	☐	Are you immuno-suppressed	☐	☐	Osteonecrosis
☐	☐	Difficulty climbing 1-2 flights of stairs	☐	☐	CPAP User___ times per week	☐	☐	Jaundice/Liver disease	☐	☐	Artificial joints
			☐	☐	Respiratory problems	☐	☐	Hepatitis A/B/C (circle one)	☐	☐	HIV or AIDS
☐	☐	Previous case of endocarditis	☐	☐	Tuberculosis	☐	☐	Stomach ulcers	☐	☐	Contagious diseases
☐	☐	Stroke/TIA	☐	☐	Emphysema	☐	☐	Eye disease/Glaucoma	☐	☐	Shingles
☐	☐	Swollen ankles, Edema	☐	☐	Tumor or growth	☐	☐	Hearing Problems	☐	☐	Sexually transmitted diseases
☐	☐	Artificial heart valves	☐	☐	Cancer type:_____	☐	☐	Parkinson's	☐	☐	A history of substance abuse
									☐	☐	A history of drug use

MEDICATION

Y	N		Y	N		Y	N	
☐	☐	Daily Aspirin	☐	☐	Anxiety Medication	☐	☐	Insulin
☐	☐	Blood Thinners (Coumadin, Plavixs, Xarelto)	☐	☐	Pain Killers	☐	☐	Muscle Relaxers
☐	☐	Thyroid Medication	☐	☐	Anti-Depressants	☐	☐	Sleeping Aids (Tylenol PM, Ambien)
☐	☐	Bone Density Medication(Fosamex, Zometa, Actonel)	☐	☐	Stimulants			

***LIST ALL MEDICATIONS YOU TAKE** (include herbal products)*

_____

_____

_____

ALLERGIES

Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Local anesthetic (numbing med)
☐	☐	Latex	☐	☐	Codeine or other narcotics
☐	☐	Sulfa drugs/sulfites	☐	☐	Anti-Anxiety meds

(LIST ANY OTHER ALLERGIES)

For women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills consult your physician/gynecologis t for assistance regarding additional methods of birth control)*

1) Is there a possibility of pregnancy? ☐ yes ☐ no
2) Expected delivery date: _____
3) Are you nursing? ☐ yes ☐ no
4) Are you taking birth control pills? ☐ yes ☐ no

I certify that I have read and I understand the ques tions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her s taff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient: X (Parent or Guardian if minor) | Reviewed by: X | Date: X

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the paper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the change. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of Patient: (Parent or Guardian if minor) X | Date: