Roger Gershfeld DMD
Cosmetic & Implant Dentistry
7063 W. Sunset Blvd.
Los Angeles, CA 90028
323-962-9707 Fax: 323-962-9717
www.rgdentistry.com

CONFIDENTAL PATIENT INFORMATION			
PATIENT NAME:	SEX: M F	BIRTHDATE:	SOC.SEC. NO:
HOME ADDRESS:		RESIDENCE PHONE:	CELL PHONE:
CITY: STATE: ZIP:		EMAIL ADDRESS:	
EMPLOYED BY:		OCCUPATION:	
BUSINESS ADDRESS:		BUSINESS PHONE:	
NAME OF SPOUSE OR PARENT (if child):		SPOUSE/PARENT PHONE NUMBER:	
IN CASE OF EMERGENCY, CONTACT:		HOME:	
NAME: RELATIONSHIP:		CELL:	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			
REASON FOR TODAY'S VISIT:			

DENTAL INSURANCE INFORMATION		
NAME OF PRIMARY DENTAL INSURANCE:	GROUP NAME:	GROUP NUMBER:
NAME OF INSURED:	SOC. SEC. NO. OF INSURED:	D.O.B. OF INSURED:
NAME OF SECONDARY DENTAL INSURANCE:	GROUP NAME:	GROUP NUMBER:
NAME OF INSURED:	SOC. SEC. NO. OF INSURED:	D.O.B. OF INSURED:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of above named patient's dental needs.
2. I authorize Dr. Gershfeld to release, receive, and share information with other health care providers regarding my medical and dental information and services I have received.
3. Upon such diagnosis, I authorize doctor or designated staff to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
4. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
5. I understand that a charge may be made for broken or missed appointments without 24 hour notice.
6. I, the undersigned, have insurance and assign directly to Dr. Gershfeld all benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
7. Lastly, I agree to be responsible for payment of all my services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed dates, I understand that a 1.5 % finance charge (18% APR) may be added to my account.

PATIENT, PARENT, OR RESPONSIBLE PARTY SIGNITURE:_____ DATE:_____

CONFIDENTIAL HEALTH HISTORY

Your complete answers to the following questions will help us better evaluate your dental needs.

NAME OF YOUR REGULAR PHYSICIAN:	PHONE:
MO/YEAR OF YOUR LAST MEDICAL EXAMINATION:	ARE YOU IN GOOD HEALTH?
PERSON TO NOTIFY IN CASE OF EMERGENCY:	PHONE:

PLEASE LIST ***ALL*** MEDICATIONS OR HERBS YOU ARE CURRENTLY TAKING (Aspirin, Coumadine, Plavix, Fosomax, Ginkgo, etc.) :

HAVE YOU EVER BEEN TOLD TO PREMEDICATE WITH ANTIBIOTICS PRIOR TO HAVING ANY DENTAL PROCEDURE?

O YES O NO

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING? (Please check all that apply)

O None	O Penicillin	O Amoxicillin	O Aspirin	O Codeine	O Tetracycline
O Erythromycin	O Valium	O Demerol	O Barbituates	O Epinephrine	O Iodine
O Latex	O Naproxen	O Other _____			

DO YOU USE TOBACCO OF ANY KIND? IF SO HOW MUCH? _____ O PER DAY O PER MONTH O PER MONTH O PAST USE

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

YES	NO		YES	NO		YES	NO	
O	O	CHEST PAIN	O	O	BYPASS SURGERY	O	O	CANCER
O	O	SHORTNESS OF BREATH	O	O	HEART ATTACK	O	O	RADIATION/CHEMO THERAPY
O	O	HIGH BLOOD PRESSURE	O	O	HIGH CHOLESTEROL	O	O	ASTHMA
O	O	LOW BLOOD PRESSURE	O	O	HEPATITIS OR JAUNDICE	O	O	EMPHYSEMA
O	O	HEART VALVE PROSTHESIS	O	O	RECEIVED TRANSFUSION	O	O	SINUS TROUBLE
O	O	MITRAL VALVE PROLAPSE	O	O	KIDNEY DISEASE	O	O	PERSISTENT COUGH
O	O	CONGENITAL HEART DEFECTS	O	O	IMPAIRED KIDNEY FUNCTION	O	O	TUBERCULOSIS
O	O	RHEUMATIC FEVER	O	O	ESOPHAGEAL REFLEX	O	O	JOINT REPLACEMENT SURGERY
O	O	HEART MURMUR	O	O	HIATAL HERNIA	O	O	ARTHRITIS
O	O	DAMAGED HEART VALVE	O	O	STOMACH ULCERS	O	O	CONNECTIVE TISSUE DISORDER
O	O	HEART ARRHYTHMIA	O	O	ANOREXIA OR BULIMIA	O	O	NEUROLOGICAL DISORDERS
O	O	CARDIAC PACEMAKER	O	O	DIABETES	O	O	STROKE
O	O	HEADACHES	O	O	MIGRAINES	O	O	EPILEPSY
O	O	SEIZURES	O	O	PSYCHIATRIC CARE	O	O	GLAUCOMA
O	O	CONTACT LENSES	O	O	CHRONIC FATIGUE	O	O	EXCESSIVE BLEEDING

DO YOU HAVE ANY DISEASE, PROBLEM, OR CONDITION NOT LISTED ABOVE? Please explain.

FOR WOMEN: CHECK ALL THAT APPLY: [ ] I AM PREGNANT [ ] I AM NURSING [ ] I AM TAKING BIRTH CONTROL PILLS [ ] MENOPAUSAL

NAME OF YOUR REGULAR DENTIST:	FOR HOW LONG?

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 3 YEARS?

[ ] LESS THAN ONCE A YEAR [ ] ONCE A YEAR [ ] TWICE A YEAR [ ] THREE TIMES A YEAR [ ] FOUR TIMES A YEAR

ARE YOU CURRENTLY SATISFIED WITH THE CONDITION & APPEARANCE OF YOUR MOUTH & TEETH?

[ ] VERY SATISFIED [ ] SATISFIED [ ] IT'S OK [ ] SOMEWHAT DISSATISFIED [ ] FOUR TIMES A YEAR

DO YOU PRESENTLY HAVE ANY PAIN OR DISCOMFORT?	DO YOU HAVE SENSITIVE TEETH?
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?
DO YOU HAVE ANY PAIN &/OR SWELLING OF YOUR GUMS?	DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH?

DO YOU OR HAVE YOU EVER HAD ANY SORENESS, PAIN, CLICKING IN THE AREA IN FRONT OF YOUR EARS OR JAW JOINT?

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT?

HAVE YOU EVER HAD BRACES?	IF SO, WHEN?
HOW OFTEN DO YOU FLOSS?	DO YOU CLENCH OR GRIND YOUR TEETH?

DOES DENTAL TREATMENT MAKE YOU NERVOUS? [ ] NO [ ] A LITTLE [ ] VERY [ ] EXTREMELY

I certify that the above statements are accurate and complete

SIGNATURE: DATE: REVIEWED BY: DATE: