CHERYL E. MCDONOUGH, DMD, APC
67 Via Pico Plaza San Clemente, CA 92672

PERSONAL INFORMATION

PATIENT Name _____ HOME Phone ( )_____

ADDRESS _____ WORK Phone ( )_____

CITY, ST, **ZIP** _____ CELL Phone ( )_____

DATE OF BIRTH _____ Which is Best Contact Number? Home___ Work___ Cell___ Email___

Marital Status _____ Your Spouse's Name _____

Patient Employer _____ Spouse's Birthdate _____

Occupation _____ Spouse's Employer _____

INSURANCE:
Primary Carrier _____

Subscriber Name _____

Subscriber DOB _____
Subscriber Employer _____

ID# OR SS# _____

Policy/Group# _____

Ins Co Phone # _____

INSURANCE:
***Secondary** Carrier* _____

Secondary Subscriber _____

2nd Subscriber DOB _____

Secondary Subscriber Employer _____

2nd ID# OR SS# _____

2nd Policy/Group# _____

2nd Ins Co Phone# _____

Person to contact in case of emergency _____ *Phone no. (_____)*_____
*How did you hear about this office?*_____

DENTAL HISTORY

When was your last dental visit? _____ Were x-rays taken? _____

Are you having any pain or discomfort from your teeth or gums now? _____ Where is the discomfort? _____

Are your teeth sensitive to hot, cold, or sweets? _____ Where is it sensitive? _____

Have you had any unfavorable reaction to previous dental treatment? _____ If so, what? _____

What kind of toothbrush do you use? _____ How often do you floss? _____

Do your gums bleed? _____ Does food collect between your teeth? _____

Do you ever have any jaw pain or discomfort when opening or closing? _____ Do you use a Night Guard or Occlusal Appliance? _____

Have you had your wisdom teeth removed? _____ Have you had orthodontic treatment? _____

What are your long-term oral health goals? _____

Anything you would like to change about your smile? _____

HEALTH HISTORY

Age_____**Height**_____**Weight**_____**Sex**_____
Physician's Name and Phone Number_____
Date of Last Complete Physical Exam_____
Are you under the care of a Physician now? _____For What Reason?_____
Are you receiving any medication? _____
If so, what medication? _____

Do you have, or have had any of the following?
CHECK appropriate box for YES or NO

						Are you ALLERGIC to any of the following?		
	Yes	No		Yes	No		Yes	No
Heart disease	□	□	Diabetes	□	□	Aspirin	□	□
Rheumatic fever	□	□	Frequent headaches	□	□	Codeine	□	□
Sinus Trouble	□	□	Liver Disease	□	□	Novocain	□	□
Use of Blood Thinner	□	□	Arthritis	□	□	Latex	□	□
History of Anxiety or Nervous Disorder	□	□	Glaucoma	□	□	Motrin/Advil	□	□
Heart Murmur	□	□	Tuberculosis	□	□	Any antibiotics	□	□
Abnormal Blood Pressure	□	□	Asthma	□	□	If yes, what antibiotic?		
Epilepsy or Convulsions	□	□	Anemia	□	□			
Tumor History	□	□	Excessive bleeding	□	□			
Cancer History	□	□	Hepatitis	□	□			
Artificial Joints or Stents	□	□	Implants	□	□			
Chemotherapy or Radiation Treatment	□	□	HIV+ or AIDS	□	□			
Are you pregnant?	□	□	Acid Reflux/GERD	□	□	Thyroid Disease	□	□
If yes, what trimester?			Take Birth Control	□	□	Depression	□	□
Do you smoke or have you ever smoked?	□	□	Drug Abuse	□	□			
For how long?_____ Years Quit_____			Alcoholism	□	□		□	□

Have you had any surgeries? Please list: _____
If you have, or have had any diseases or conditions not listed above, please describe below:
_____

CONSENT
After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.
Date_____ Signature_____Relationship_____

Terms and Conditions
This office depends on reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
Assignment of Insurance: I hereby authorize release of any insurance information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for the dental care can only be extended for a period of 90 days from the date of the patient's exam. I also understand that in order to collect my debt my credit history may be checked through the use of my social security number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered; the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions and agree to their content.

Date_____Signature_____Relationship_____