

# WELCOME TO WILSHIRE PARK DENTAL GROUP

3700 Wilshire Blvd. #780, Los Angeles, CA 90010  
 3420 Bristol St., #330, Costa Mesa, CA 92626  
 7872 Walker St., #101, La Palma, CA 90623

Ph: 213-380-7900  
 Ph: 714-689-2200  
 Ph: 714-670-0023

Patient's Name <i>Mr. / Mrs. / Miss / Dr</i>			Birthdate
Address <i>City</i> <span style="float: right;"><i>ZIP</i></span>			Home Phone
Employer's Name / Address			Business Phone / Cell Phone
Social Security Number	Driver's License #	Occupation	
Dental Insurance ? Yes ___ No ___	Insurance Company Name	Group/Policy #	
2 nd Insurance ? Yes ___ No ___	Insurance Company Name	Group/Policy #	
Subscriber's Name/Relationship ( If different)		Subscriber's Social Security Number	
Subscriber's Birthdate		Subscriber's Employer/Phone	
Nearest friends or relative not residing with you		Phone	Relationship to patient

1. Referred by WPD patient ( ) Name: \_\_\_\_\_  
 Referred by other dentists/doctors ( ) Name : \_\_\_\_\_  
 Referred by Others ( ) Name : \_\_\_\_\_
2. WPDG Newsletter "Health & Smile" ( ) Insurance Company ( ) \_\_\_\_\_
3. Media Newspaper ( ) Radio ( )  
 T . V ( ) \_\_\_\_\_ Directory ( ) \_\_\_\_\_  
 Magazine ( ) \_\_\_\_\_ WpD Website ( ) \_\_\_\_\_

I authorize this office to release any information necessary to expedite insurance claims.  
 I understand that I am financially responsible for all charges, regardless of insurance coverage.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

**HEALTH QUESTIONNAIRE**

Please answer each question Yes or No where applicable.

**Medical History**

1. Are you in good health ? Yes      No
2. Are you now under the care of a physician ? Yes      No  
 If Yes , Physicians Name and phone # \_\_\_\_\_
3. Have you ever had any serious illness, operation or hospitalization ? Yes      No
4. Are you taking any drugs or medications ? Yes      No  
 If Yes , please list \_\_\_\_\_
5. Do you have allergies or sensitivity to any drugs ? Yes      No  
 If Yes, please explain \_\_\_\_\_
6. Name, address and phone number of your previous dentist? \_\_\_\_\_  
 \_\_\_\_\_
7. Reason for leaving previous dentist? \_\_\_\_\_

8. Do you have any of the following conditions past or present ? (Please circle Y or N as applicable)

High Blood Pressure	Y	N	Diabetes	Y	N	Anemia	Y	N
Heart Ailments	Y	N	Lung Ailments	Y	N	Liver Ailments	Y	N
Heart Murmur	Y	N	Stomach Ulcer	Y	N	Stroke	Y	N
Blood Disease	Y	N	Excessive Bleeding	Y	N	Tumor	Y	N
Venereal Disease	Y	N	Kidney Disease	Y	N	HIV/AIDS	Y	N
Epilepsy	Y	N	Hepatitis	Y	N	Arthritis	Y	N
Artificial Joint	Y	N	Nervous Disorder	Y	N	Glaucoma	Y	N
Sinus Problem	Y	N	Fainting	Y	N	Alcoholism	Y	N
Latex Allergy	Y	N	Smoking	Y	N	Phen-fen use	Y	N
Metal Allergy	Y	N	Jaw / Joint Pain / TMJ	Y	N	Osteoporosis	Y	N
Chemotherapy	Y	N	Radiation Therapy	Y	N	Corticosteroid use	Y	N

7.(WOMEN) Are you pregnant ? Yes No If Yes, how many months? \_\_\_\_\_

**Dental History**

1. Are you having discomfort or pain at this time? Yes      No  
 If Yes, please describe \_\_\_\_\_
2. Have you ever had any unfavorable reaction to a dental treatment? Yes      No
3. Are you dissatisfied with your previous dentist or dental treatment? Yes      No
4. Does dental treatment make you nervous? Yes      No
5. Do you like your smile? Yes      No  
 If No, would you like to know how to improve your smile? Yes      No
6. What is your chief complaint? \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Doctor Signature /Date Patient Signature Date

**UPDATES**

\_\_\_\_\_  
**Doctor Signature /Date** **Patient Signature / Date**  
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