Dental Wellness Center

Robert P. McBride, D.D.S., M.A.G.D

Denture New Patient Form

Dental Wellness Center
5406 E. Village Road
Long Beach , CA , 90808
(562) 421-3747
www.LongBeachHolisticDentist.com
leanne@rpmdentistry.com

____ ____________ ____________ ____________ Appointment date: __________
Last Name First Name Middle Name

Prefer to be called: ______________________ Birth Date: __________

Address: ______________________

City: __________ State: __________ Zip Code: __________

Home Ph. __________ Bus. Ph. __________ Usual Ph: __________

Referred by: ______________________

Personal History

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced How long? ______

Hobbies: __________ Social activities: __________

Present Pursuit(s): ______________________

Recent life changes? ______________________

Children: __________ Grandchildren: __________

Height: ______ Weight: (present) ______ (usual): ______ Exercise: ______ Sleep: ______

Liquid Intake/day: __________ Diet: __________

Alcohol: __________ Tobacco: __________ Chewing habits: __________

Contact lenses (progressive lenses)? ◯ Yes ◯ No How well tolerated? __________

Medical History

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

Family Physician: __________ Date of last visit: __________

Specialty: __________ Date of last complete physical: __________

Address: ______________________

City: __________ State: ______ Zip Code: ______ (Area Code) Phone # __________

Additional Physician: __________ Date of last visit: __________

Specialty: ______________________

Address: ______________________

City: __________ State: ______ Zip Code: ______ (Area Code) Phone # __________

Additional Physician or Health Provider, such as Chiropractor, Naturopath, Homeopath, Acupuncturist, etc.

__________ Date of last visit: __________

Address: ______________________

City: __________ State: ______ Zip Code: ______ (Area Code) Phone # __________

Please check YES or NO.

1. Do you have a current medical problem? ◯ Yes ◯ No
   If yes, please explain: ______________________________
   ____
2. Are you currently under the care of a physician? ◯ Yes ◯ No
   If yes, who? ______________________________
3. Have you been hospitalized or had a serious illness within the past 5 years? ◯ Yes ◯ No
   If YES, please explain: ______________________________
4. Do you have heart trouble or any form of cardiovascular disease? ◯ Yes ◯ No
   If YES, indicate below:
   - ☐ Angina (chest pains) Frequency __________
   - ☐ Heart Attack (date) __________
   - ☐ Heart Surgery (date) __________
     - ☐ Pacemaker
     - ☐ Bypass
     - ☐ Prosthetic heart valve
   - ☐ Stroke (date) __________
   - ☐ Blood Pressure, if known __________
   - ☐ Rheumatic Fever (date) __________
   - ☐ Heart Murmur
   - ☐ High Blood Pressure
   - ☐ Low Blood Pressure
   - ☐ Congenital Heart lesions
   - ☐ Atherosclerosis
   - ☐ Other: __________
5. Are you ever short of breath after mild exercise? ◯ Yes ◯ No
6. Do your ankles swell? ◯ Yes ◯ No
7. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ◯ Yes ◯ No
8. Do you have diabetes? ◯ Yes ◯ No Prediabetes? ◯ Yes ◯ No
   If YES, how is it controlled? ☐ Diet ☐ Oral Medication ☐ Injections
9. Do you have hypoglycemia? ◯ Yes ◯ No
   If YES, how is it controlled? ______________________________
10. Do you have kidney disease? ◯ Yes ◯ No
11. Have you ever had hepatitis? ◯ Yes ◯ No
    If YES, Date? __________
    ☐ Type A Infectious (Food) ☐ Type B Serum (Blood) ☐ Type C (non-A, non-B) ☐ Unknown
    If Unknwon, Explain: ______________________________
12. Have you ever had liver disease or jaundice? ◯ Yes ◯ No
    If YES, Date: __________
13. Do you have any blood disease? ◯ Yes ◯ No
    ☐ Anemia ☐ AIDS or HIV positive test ☐ Leukemia ☐ Venereal disease
    ☐ Other: ______________________________
14. Do you have any problems with excessive bleeding? ◯ Yes ◯ No
    If YES, please explain: ______________________________
15. Do you bruise easily? ◯ Yes ◯ No
16. Do you have stomach or intestinal ulcers? ◯ Yes ◯ No
17. Have you ever had tuberculosis? ◯ Yes ◯ No
    If YES, Date: __________
18. Do you have emphysema, asthma or breathing problems? ◯ Yes ◯ No

Please check YES or NO.

19. Do you have any form of arthritis? ◯ Yes ◯ No
   ☐ Rheumatoid Arthritis ☐ Gout/Gouty Arthritis ☐ Osteoarthritis
   ☐ Other: ______________________
   Which joints are involved? ______________________
20. Do you have any orthopedic or tissue repair implants in your body such as pins, plates, screws or artificial joints? ◯ Yes ◯ No
   If yes, please list them as best you can: ______________________
21. Do you have fainting spells, convulsions or epilepsy? ◯ Yes ◯ No
22. Have you had surgery, radiation or treatment for a tumor or growth? ◯ Yes ◯ No
   If YES, what area(s)? ______________________
23. Do you have glaucoma? ◯ Yes ◯ No
   ◯ Right eye ◯ Left eye ◯ Both eyes
24. Your height: ____________
25. Current body weight: ________ Have you gained ☐ or lost ☐ weight within the last year?
   How much? ____________
26. Is your diet medically prescribed? ◯ Yes ◯ No
   If YES, please explain. ______________________
27. Are you taking vitamins? ◯ Yes ◯ No
   What kind and dosages? ______________________
28. Are you currently taking any herbal medicines? ◯ Yes ◯ No
   If so, what kind? ______________________
29. Are you using food supplements? ◯ Yes ◯ No
   What? ______________________
30. Do you frequently not eat breakfast? ◯ Yes ◯ No
31. Do you become fatigued easily? ◯ Yes ◯ No
   At what time of day? ______________________
32. Have you been told, or are you aware that you have a tendency for snoring? ◯ Yes ◯ No
33. Do you feel rested after 7 hours of sleep? ◯ Yes ◯ No
34. Are you sleepy or do you feel you are dragging during the day? ◯ Yes ◯ No

Questions 35-36 are For Women Only

35. Is there a possibility that you may be pregnant? ◯ Yes ◯ No
   If so, expected delivery date: ____________
36. Do you have a history of miscarriages? ◯ Yes ◯ No
37. Are you allergic to or have you had any unusual reaction to any of the following? ◯ Yes ◯ No
   ☐ Penicillin
   ☐ Erythromycin
   ☐ Sulfa drugs
   ☐ Codeine
   ☐ Aspirin
   ☐ Sleeping pills
   ☐ Barbiturates
   ☐ Other antibiotics: ____________
   ☐ Local anesthetics
   ☐ Novocaine
   ☐ Xylocaine
   ☐ Nitrous oxide
   ☐ Epinephrine
   ☐ Other pain medications: ____________
   ☐ Any other drug allergies? ____________

Please check YES or NO.

38. Do you have a current medical problem? ◯Yes ◯No
    If YES, please list: ______________________________

39. Have you ever been advised to take prophylactic antibiotics before dental treatment? ◯Yes ◯No

40. Have you ever used Phen Fen or other appetite suppression combinations for weight loss? ◯Yes ◯No
    If the answer to question #40 is positive, have you had an echocardiogram? ◯Yes ◯No

41. Are you taking/have you taken bisphosphonate medication (Zometa, Fosomax, Didronel, Actonel, Aclasta?) ◯Yes ◯No
    If so, for how long/how long ago? ______________________________

Please indicate if you are taking any of the following medications:

	Name	Purpose	Frequency	Since
☐ Heart Medication				
☐ Blood Pressure Medication				
☐ Cholesterol lowering				
☐ Insulin				
☐ Nitroglycerine				
☐ Blood Thinner Medication				
☐ Antibiotics				
☐ Sedatives				
☐ Tranquilizers				
☐ Anti Depressants				
☐ Pain Medication				
☐ Cortisone (Steroids)				
☐ Thyroid				
☐ Birth Control Pills				
☐ Over Counter Medications				
☐ Medicinal Patches				
☐ Other: ____________				

Please name the pharmacy you use. ____________ City: ____________ Phone: ____________

☐ Alcohol ______ drinks per day

☐ Tobacco ______ packs per day for approximately _____ years

☐ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

42. there a disease, condition or problem not listed above that you think I should know of? ◯Yes ◯No
    If yes, what? ______________________________

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature: ______________________________ Date: ____________

Dental Health History

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Your answers to this dental history questionnaire will help us to understand your specific dental problems, so that we may more effectively treat you with consideration of your individual needs.

Specialty Dentist: ______________________ Period of Treatment : ______________________

Address: ____

City: ______________ State: ______________ Zip: ______________

E-mail: ______________________ Phone: ______________________

Date of last complete x-rays? ___/___ Date of last oral cancer screening ___/___ Date of last cleaning? ___/___

What is the primary reason you selected the Dental Wellness Center? ______________________

Please check conditions that apply to you

- ☐ Sensitivity to: ☐ Pressure from biting or chewing ☐ Hot ☐ Cold ☐ Sweet
- ☐ Chipped/Broken Teeth
- ☐ Teeth wearing away abnormally
- ☐ Crooked or Tipped Teeth
- ☐ Loose Teeth
- ☐ Missing Teeth
- ☐ Gaps/Food Traps between teeth
- ☐ Dry Mouth or Constantly Thirsty
- ☐ Burning Sensation in Mouth/Tongue
- ☐ Smoke or Use Chewing Tobacco
- ☐ Growths or Swellings in Mouth
- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Grooves or Recession at Gumline
- ☐ Allergic to Dental Materials
- ☐ Oral Malodor (Bad Breath)
- ☐ Bad Taste
- ☐ Dissatisfied With Appearance of My Teeth
- ☐ Teeth Clenching ☐ Teeth Grinding
- ☐ Uncomfortable Bite ☐ Uneven Bite
- ☐ Changing Bite
- ☐ Jaw Joint (TMJ) Pain/Soreness/Discomfort Jaw Joint
- ☐ (TMJ) Noise (Popping/Clicking)
- ☐ Ringing in The Ears (tinnitus)
- ☐ Difficulty in Opening Mouth ☐ Difficulty in Chewing
- ☐ Headaches/Migraines
- ☐ Pain or Soreness Around ☐ Eyes ☐ Ears
- ☐ Vertigo, Dizziness or Balance Problems
- ☐ Pain ☐ Stiffness ☐ Facial ☐ Head ☐ Neck ☐ Shoulder

Please check all areas that apply to you

- ☐ Dentures or Removable Partial Dentures
- ☐ Fixed Bridge
- ☐ Braces or Clear Braces
- ☐ Dental Implants
- ☐ Crowns
- ☐ Veneers
- ☐ Any Serious Trouble With Past Dental Treatment
- ☐ Unusual Reaction to Dental Anesthesia ("Shots") Jaw
- ☐ Surgery
- ☐ Root Canals
- ☐ Sleep Apnea
- ☐ CPAP Machine or Sleep Appliance
- ☐ Night Guard
- ☐ Fear or anxiety level regarding dental treatment

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

If I could change my smile, I would:

- [ ] Make My Teeth Whiter
- [ ] Make My Teeth Straighter
- [ ] Close Spaces or Gaps That Bother Me
- [ ] Replace Dark Fillings With Tooth Colored Replacements
- [ ] Fix My Teeth So I'm Not Embarrassed To Smile
- [ ] Repair Chipped Teeth
- [ ] Fix "Gummy" Smile
- [ ] Replace Missing Teeth
- [ ] Replace Old Crowns That Don't Fit Right or Match
- [ ] Have A Smile Makeover
- [ ] Stop My Jaw From Hurting or Clicking
- [ ] Stop My Gums From Bleeding

On a scale of 1 - 10, with 10 being the highest rating:

	1	2	3	4	5	6	7	8	9	10
How important is your dental health to you?	○	○	○	○	○	○	○	○	○	○
Where would you rate your current dental health?	○	○	○	○	○	○	○	○	○	○

Family Medical/Dental History

Please check any condition that applies to your parents (Mother/Father)

Condition		
Heart disease	☐ Mother	☐ Father
Heart attack	☐ Mother	☐ Father
High blood pressure	☐ Mother	☐ Father
Stroke	☐ Mother	☐ Father
Low blood pressure	☐ Mother	☐ Father
Diabetes	☐ Mother	☐ Father
Cancer	☐ Mother	☐ Father
Pre-term birth	☐ Mother	☐ Father
Gum disease	☐ Mother	☐ Father
Tooth loss	☐ Mother	☐ Father
Dentures	☐ Mother	☐ Father

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Reasons for previous extractions: ____________________

Date of most recent extractions: ____________________

Complications? ____________________

Did you wear partial dentures prior to having all teeth removed? ◯ Yes ◯ No

If yes, how long? __________ How many? __________

Were your partial denture experiences positive? __________ Negative? __________

If negative, why? ____________________

1st Full Denture(s): Seating Date: __________ Placed same day as extractions? __________

Length of time 1st dentures worn? ____________________

Subsequent Dentures

Dates	Reasons for replacement

Which ones are you wearing now? ____________________

Main reason for having new dentures:

- ☐ Difficulty in chewing
- ☐ Discomfort
- ☐ Esthetics

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Dental Insurance

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Insurance benefits vary considerably from contract to contract. In spite of our efforts, we find it impossible to be sure what you will get back ... it's very frustrating.

Although we are not contracted with any dental insurance companies, for those of you that have dental insurance that allows freedom of choice of dentists, we fully commit to obtaining any and all benefits that lie within your contract. If you would be interested in learning why we are not contracted with 3rd parties, go to our website, www.LongBeachHolisticDentist.com, click the "Resources" tab, go to articles, and scroll down to the "Dental Insurance Misnomer" article.

The financial obligation for dental treatment is between you and our office - your insurance company is responsible to you, and not to our office. We will assist you in any way that we can.

To expedite your receiving all benefits due you, please fill out the following:

Name of Insured : ______________________________

Birth date: ______________________________ Social Security Number: ______________________________

Employer Name: ______________________________

Insurance company (Carrier) name: ______________________________

Name of Group Plan: ______________________________ Group number: ______________________________

Address of insurance company: ______________________________

City: ____________________ State: ____________________ Zip Code: ____________________

Phone number of insurance company: ______________________________

If you have secondary dental insurance:

Name of other insured party: ______________________________

Social Security Number: ______________________________ Date of Birth of other insured party: ______________________________

Employer Name: ______________________________

Insurance company (Carrier) name: ______________________________

Name of Group Plan: ______________________________ Group number: ______________________________

Address of insurance company: ______________________________

City: ____________________ State: ____________________ Zip Code: ____________________

Phone number of insurance company: ______________________________

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Financial Menu

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Client: ______________________________ Date: ______________

Dental treatment is an excellent investment in an individual's physical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

PAYMENT OPTIONS:

Two Payments (for treatment over $1,000 that have more than one visit)
Total patient obligation may be divided as follows: 50% due at the first treatment visit, with the remaining balance paid at last visit. For any fees under $1,000, the full amount is due at the initiation of any procedure.

Treatments today ... Payments tomorrow ...
We are pleased to offer Care Credit. It is convenient, no initial payment, low monthly payment plan for dental treatments of $200 to $25,000. Offering Care Credit allows us to make the smile you've always wanted affordable.

Apply from home:
Care Credit: 1-800-365-8295

Apply online 24 hours, 7 days a week:
Care Credit: www.carecredit.com

Pay as You Go. You may choose to pay your entire obligation for each visit, at the visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): **Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks or Care Credit (see above).**

I have read and understand all the above ______________________________
Patient Signature