Today's Date _____

Camarillo Smiles

beautiful smiles, smartly done.

Dr. Czubiak, Dr. Shapiro and Dr. Pezeshki and the whole team at Camarillo Smiles welcome you to our practice. We are so glad you are here. The benefits of a healthy smile are immeasurable. Our goal is to help you reach and maintain optimal oral health.

Please fill out the form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Name: _____ (Last / First / Mi / Mr Mrs Ms Dr)

I preferred to be called: _____ ☐ female ☐ male

Birth Date: ___/___/___ Age: _____ SS#: _____

Home Address: _____

_____

☐ single ☐ married ☐ partnered ☐ divorced ☐ widowed

Home #: (___) _____ Cell#: (___) _____

Work#: (___) _____

Where & when are the best times to reach you? _____

Email Address: _____

We often use email and text for appointment reminders, check if you would like these reminders: ☐ email ☐ text

Other family members seen by us: _____

Whom may we thank for referring you? _____

Employer: _____

How long there? _____ Occupation: _____

Name of Spouse/Partner/Friend: _____ (circle one)

Their Cell#: _____

Person responsible for account _____

INSURANCE AND BILLING INFORMATION

We provide the courtesy of filing your insurance claims on your behalf. Please provide us with your Insurance ID card at time of registration.

Dental Insurance Company _____

Group # (plan, local, or policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ___/___/___ Insured's ID # _____

Insured's Employer: _____

Secondary Insurance Company _____

Group # (plan, local, or policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ___/___/___ Insured's ID # _____

Insured's Employer: _____

DENTAL HISTORY

Date of last dental care: _____

Reason for today's visit: _____

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

How often do you brush? _____ floss? _____

Type of bristles on your brush: ☐ Hard ☐ Medium ☐ Soft

Previous/Present Dentist _____

Do you clench or grind your teeth? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had TMJ (jaw) problems? ☐ Yes ☐ No

Do you like the way your teeth look? ☐ Yes ☐ No

Would you like to have whiter teeth? ☐ Yes ☐ No

Would you like to have straighter teeth? ☐ Yes ☐ No

Would you like to have fresher breath? ☐ Yes ☐ No

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my Insurance does not cover, as well as any collection fees. I hereby authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits. I understand that a fee may be charged for broken appointments as well as appointments canceled with less than 24 hours notice.

_____

Signature Date

Camarillo Smiles
92 Palm Dr. Camarillo, CA 93010 (805) 388-5700

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MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name: _____

Physician's # _____ Date of last visit _____

Any changes in your health within the last year? Yes No

Please explain _____

Are you currently under the care of a physician? Yes No

Please explain _____

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No

Have you taken Fosamax or any Bisphosphonate? Yes No

Have you ever taken Phen-Fen (Redux, Pondimin)? Yes No

Women: Are you pregnant? Yes No

Women: Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Y N Abnormal bleeding
Y N AIDS/HIV
Y N Alcohol/Drug abuse
Y N Angina
Y N Anemia
Y N Arthritis, rheumatism
Y N Artificial heart valve
Y N Artificial joint
Y N Asthma
Y N Blood disease
Y N Cancer
Y N Chemotherapy
Y N Circulatory problems
Y N Colitis
Y N Congenital heart defect
Y N Coronary heart disease
Y N Diabetes
Y N Fainting
Y N Family history of heart disease
Y N Frequent headaches
Y N Glaucoma
Y N Heart attack
Y N Heart surgery
Y N Hepatitis A/B/C
Y N Herpes/Cold sores
Y N High blood pressure
Y N Kidney disease
Y N Liver disease
Y N Low blood pressure
Y N Lupus
Y N Osteoporosis
Y N Pacemaker
Y N Psychiatric care
Y N Radiation treatment
Y N Respiratory disease
Y N Rheumatic/Scarlet fever
Y N Seizures
Y N Sexually transmitted disease
Y N Shortness of breath
Y N Stomach problems/ulcers
Y N Stroke
Y N Swelling of feet/ankles
Y N Thyroid problem
Y N Transplant
Y N Tuberculosis

MEDICATIONS

List medications that you are currently taking:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Local anesthetic
Y N Valium
Y N Penicillin
Y N Erythromycin
Y N Tetracycline
Y N Vicodin
Y N Metal
Y N Food
Y N Other _____

OTHER

Do you have or have you had any other diseases or medical problems not listed on this form? Yes No

Please explain _____

Would you like to speak to the doctor privately about any problem? Yes No

For office use only

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

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