

## Patient Information

### Confidential Information Questionnaire

Patient Legal Last Name \_\_\_\_\_

First Name \_\_\_\_\_

M.I. \_\_\_\_\_

Date Of Birth \_\_\_\_\_

Sex ☐ Male ☐ Female

Social Security # \_\_\_\_\_

Prefer to Be Called ☐ Home ☐ Cell ☐ Work

Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

### Patient's Address

Address \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Email \_\_\_\_\_

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Under 18

Patient's/Guardian's Employer \_\_\_\_\_

Occupation \_\_\_\_\_

### Employer

Employer Name \_\_\_\_\_

Phone Number \_\_\_\_\_

### Emergency Contact Information

**Person We May Contact In Case of an Emergency  
(Other Than Your Family Home)**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

### Insurance and Financial Information

Insurance Coverage ☐ Yes ☐ No

Insurance Company Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday \_\_\_\_\_

Subscriber's SSN / ID # \_\_\_\_\_

Group / Program Number \_\_\_\_\_

Employer (If Different from above) \_\_\_\_\_

Employer's Address \_\_\_\_\_

### Secondary Coverage

Insurance Name \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Patient's relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday \_\_\_\_\_

Subscriber's SSN / ID # \_\_\_\_\_

Group / Program Number \_\_\_\_\_

Employer (If Different from above) \_\_\_\_\_

Employer Address \_\_\_\_\_

### Release Information

**You May Discuss My Healthcare With**

Health Care Providers ☐ Yes ☐ No Insurance Companies ☐ Yes ☐ No

### Referral Information

**Whom may we thank for referring you to our practice?**

☐ Postcard to House

☐ Other

☐ Website/Internet Search

☐ Referral

☐ Saw Office While in Building (Walk In)

Name: \_\_\_\_\_

### Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he/she so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

\_\_\_\_\_  
Signature-Patient/Guardian

\_\_\_\_\_  
Date



3050 Main Street  
Lemon Grove, CA 91945

**Dr. Kevin Swartzberg**

619 463 9931

staff@teethbykevin.com

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# Medical History Form

## Medical History

### Do you have or have you ever had:

Hospitalization for illness or injury

☐ YES ☐ NO

An allergic reaction to

- |  |  |
|--|--|
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Sulfa                         |
| <input type="checkbox"/> Ibuprofen     | <input type="checkbox"/> Local anesthetic              |
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Fluoride                      |
| <input type="checkbox"/> Codeine       | <input type="checkbox"/> Metals (nickel, gold, silver) |
| <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Latex                         |
| <input type="checkbox"/> Erythromycin  | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Tetracycline  |  |

Heart problems, or cardiac stent within the last six months

☐ YES ☐ NO

History of infective endocarditis

☐ YES ☐ NO

Artificial heart valve, repaired heart defect (PFO)

☐ YES ☐ NO

Pacemaker or implantable defibrillator

☐ YES ☐ NO

Artificial prosthesis (heart valve or joint)

☐ YES ☐ NO

Rheumatic or scarlet fever

☐ YES ☐ NO

High or low blood pressure

☐ YES ☐ NO

A stroke (taking blood thinners)

☐ YES ☐ NO

Anemia or other blood disorder

☐ YES ☐ NO

Prolonged bleeding due to a slight cut (INR > 3.5)

☐ YES ☐ NO

Emphysema, sarcoidosis

☐ YES ☐ NO

Tuberculosis

☐ YES ☐ NO

Asthma

☐ YES ☐ NO

Breathing or sleep problems (I.E. snoring, sinus)

☐ YES ☐ NO

Kidney disease

☐ YES ☐ NO

Liver disease

☐ YES ☐ NO

Jaundice

☐ YES ☐ NO

Thyroid, parathyroid disease, or calcium deficiency

☐ YES ☐ NO

Hormone deficiency

☐ YES ☐ NO

High Cholesterol or taking statin drugs

☐ YES ☐ NO

Diabetes (HbA1c=\_\_\_)

☐ YES ☐ NO

Stomach or duodenal ulcer

☐ YES ☐ NO

Digestive disorders (I.E. gastric reflux)

☐ YES ☐ NO

Osteoporosis/ osteopenia (i.e. taking bisphosphonates)

☐ YES ☐ NO

Arthritis

☐ YES ☐ NO

Glaucoma

☐ YES ☐ NO

Contact lenses

☐ YES ☐ NO

Head or neck injuries

☐ YES ☐ NO

Epilepsy, convulsions (seizures)

☐ YES ☐ NO

Neurologic problems (attention deficit disorder)

☐ YES ☐ NO

Viral infections and cold sores

☐ YES ☐ NO

Any lumps or swelling in the mouth

☐ YES ☐ NO

Hives, skin rash, hay fever

☐ YES ☐ NO

STI/STD

☐ YES ☐ NO

Hepatitis

☐ YES ☐ NO

HIV/AIDS

☐ YES ☐ NO

Tumor, abnormal growth

☐ YES ☐ NO

Radiation therapy

☐ YES ☐ NO

Chemotherapy

☐ YES ☐ NO

Emotional problems

☐ YES ☐ NO

Psychiatric treatment

☐ YES ☐ NO

Antidepressant medication

☐ YES ☐ NO

Alcohol/street drug use

☐ YES ☐ NO

### Do you have or have you ever had:

Presently being treated for any other illness

☐ YES ☐ NO

Aware of a change in our health (i.e. fever, new cough)

☐ YES ☐ NO

Taking medication for weight management (I.E. fen-phen)

☐ YES ☐ NO

Taking dietary supplement

☐ YES ☐ NO

Often exhausted or fatigued

☐ YES ☐ NO

Experiencing frequent headaches

☐ YES ☐ NO

A smoker, smoked previously or use smokeless tobacco

☐ YES ☐ NO

Considered a touchy person

☐ YES ☐ NO

Often unhappy or depressed

☐ YES ☐ NO

FEMALE-taking birth control pills

☐ YES ☐ NO

FEMALE- pregnant

☐ YES ☐ NO

MALE- prostate disorders

☐ YES ☐ NO

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possible affect your dental treatment. (I.E. Botox, Collagen Injections):

List all medications, supplements, and or vitamins taken within the last two years

Please advise us in the future of any change in your medical history or any medications you may be taking.

Signature-Patient/Guardian

Date

Doctor Signature

Date

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# Dental History Form

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_

How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist \_\_\_\_\_

How long have you been a patient? \_\_\_\_\_ Months \_\_\_\_\_ Years

Date of most recent dental exam \_\_\_\_\_ Date of most recent x-rays \_\_\_\_\_ Date of most recent treatment (other than a cleaning) \_\_\_\_\_

I routinely see my dentist every? ☐3mo. ☐4mo. ☐6mo. ☐12mo. ☐Not routinely

What is your immediate concern? \_\_\_\_\_

## Please Answer the following:

### Personal History

Are you fearful of dental treatment? ☐YES ☐NO

How fearful on a scale of 1 (least) to 10 (most)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Have you had an unfavorable dental experience? ☐YES ☐NO

Have you ever had complications from past dental treatment? ☐YES ☐NO

Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐YES ☐NO

Did you ever have braces, orthodontic treatment or had your bite adjusted? ☐YES ☐NO

Have you had any teeth removed? ☐YES ☐NO

### Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ☐YES ☐NO

Have you ever whitened (bleached) your teeth? ☐YES ☐NO

Have you felt uncomfortable or self conscious about the appearance of your teeth? ☐YES ☐NO

Have you been disappointed with the appearance of previous dental work? ☐YES ☐NO

### Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ☐YES ☐NO

Do you / would you have any problem chewing gum? ☐YES ☐NO

Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? ☐YES ☐NO

Have your teeth changed in the last 5 years, become shorter, thinner or worn? ☐YES ☐NO

Are your teeth crowding or developing spaces? ☐YES ☐NO

Do you have more than one bite and squeeze to make your teeth fit together? ☐YES ☐NO

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐YES ☐NO

Do you clench your teeth in the daytime or make them sore? ☐YES ☐NO

Do you have any problems with sleep or wake up with an awareness of your teeth? ☐YES ☐NO

Do you wear or have you ever worn a bite appliance? ☐YES ☐NO

### Tooth Structure

Have you had any cavities within the past 3 years? ☐YES ☐NO

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐YES ☐NO

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐YES ☐NO

Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ☐YES ☐NO

Do you have grooves or notches on your teeth near the gum line? ☐YES ☐NO

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐YES ☐NO

Do you frequently get food caught between any teeth? ☐YES ☐NO

### Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ☐YES ☐NO

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐YES ☐NO

Have you ever noticed an unpleasant taste or odor in your mouth? ☐YES ☐NO

Is there anyone with a history of periodontal disease in your family? ☐YES ☐NO

Have you ever experienced gum recession? ☐YES ☐NO

Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ☐YES ☐NO

Have you experienced a burning sensation in your mouth? ☐YES ☐NO

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date



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## Consent for Services for Patient

### Patient Name

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Preferred Name \_\_\_\_\_

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. I also understand that any returned checks or insufficient payments will be assessed a \$25 fee and the entire balance will be required to be paid immediately. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expense and court cost incurred in the collection.

As a condition of treatment by this office, financial arrangements must be determined before treatment. As a courtesy to our insurance patients, we file your dental insurance. We will always do our best to help you maximize your dental benefits, however ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment.

I understand if I cancel an appointment with less than 24 hour notice, there may be a failed appointment fee which I agree to pay before any further appointments can be made.

I acknowledge that I have reviewed the Teeth by Kevins's Notice of Privacy Practices on **www.teethbykevin.com** and can get a copy upon request.

I grant my permission to you or your assignee, to telephone me to discuss this statement, my account, appointments or my treatment.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

\_\_\_\_\_  
Signature-Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Response date

\_\_\_\_\_  
Relationship to Patient



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