# Olive Dentistry

239 West Olive Ave | Suite #101 • Burbank, CA 91502
silberbergdental@gmail.com
(818)639-9333

**Welcome to our Practice**

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Title:** _____ **Gender** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

**Birth Date:** _____ **SS#:** _____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____ _____
Address 1 Address 2

_____ ___ _____
City State Zip Code

**The following is for** ☐ the patient ☐ the person responsible for payment ☐ both ☐ not applicable

**Employer Name:** _____ **Phone:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ ___ _____
City State Zip Code

Whom may we thank for referring you to our practice?

**Referral Name:** _____

**In an emergency who should be notified? Please enter Name and Phone number below:**

_____

_____

**Primary Dental Insurance:**

**Name of Insured:** _____ _____ ___
Last First MI

**Insured's Birth Date:** _____

**ID#:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ ___ _____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Patient's relationship to insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insurance Authorization:**

☑ **By checking this box,**
**I authorize my insurance to pay my benefits directly to the dentist for all services rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges, whether or not paid by insurance.**

**Secondary Dental Insurance**

**Name of Insured:** _____ _____ _____
Last First MI

**Insured's Birth Date:** _____

**ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Patient's relationship to insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

**Insurance Authorization:**

☑ **By checking this box,**
**I authorize my insurance to pay my benefits directly to the dentist for all services rendered.**
**I authorize the use of this electronic signature on all insurance submissions.**
**I authorize the dentist to release all information necessary to secure the payment of benefits.**
**I understand that I am financially responsible for all charges, whether or not paid by insurance.**

## Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ *Pre-Med - Amox
- ☐ Allergies
- ☐ Allergy - Clindamycin
- ☐ Allergy - Erythro
- ☐ Allergy - Lisinopril
- ☐ Allergy - Sulfa
- ☐ Arthritis
- ☐ Basal Cell Carcinoma
- ☐ COVID 19
- ☐ Cholesterol
- ☐ Depression
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ G.E. reflux
- ☐ Hashimotos Disease
- ☐ Heart Murmur
- ☐ Insomnia
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Renal Sepsis
- ☐ Rhinoplasty
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Tinnitus
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Amox.
- ☐ Allergy - Codeine
- ☐ Allergy - Hay Fever
- ☐ Allergy - Novacain
- ☐ Alzheimer's Disease
- ☐ Artificial Joints
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Colitis
- ☐ Dermatomyositis
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Lupus
- ☐ Migraine
- ☐ Neuropathy
- ☐ Other
- ☐ Prostate Cancer
- ☐ Respiratory Problems
- ☐ SVT
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ *Pre-Med - Other
- ☐ Allergy - Aspirin
- ☐ Allergy - Dilantin
- ☐ Allergy - Iodine
- ☐ Allergy - Other
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cardiac Stents
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Fainting
- ☐ Gout
- ☐ Headaches
- ☐ Hernia
- ☐ Kidney Disease
- ☐ Lyme Disease
- ☐ Mitral ValveProlapse
- ☐ Osteogenesis Imperfecta (OI)
- ☐ Pacemaker
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Sarcoma
- ☐ Smoker (Currently)
- ☐ Thrombocytosis
- ☐ Tumors
- ☐ Wolff-Parkinson-White
- ☐ ADHD
- ☐ Allergy - Bactrim
- ☐ Allergy - Doxycycline
- ☐ Allergy - Latex
- ☐ Allergy - Penicillin
- ☐ Anxiety
- ☐ Autism
- ☐ COPD
- ☐ Celiac Disease
- ☐ Dementia
- ☐ Dialysis
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ HIV
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Knee Replacement
- ☐ Meniere Disease
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Shingles
- ☐ Smoker (Previously)
- ☐ Thyroid Problems
- ☐ Ulcers

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

**Are you taking any bisphosphonate medication? (prevents bone loss, including conditions like osteoporosis and certain cancers). May include medications like Fosamax, Actonel, or Boniva?**

_____

_____

**If any condition or alert selected above needs further clarification, please explain below:**

_____

_____

**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

**What is your estimate of your general health?**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Name of physician and their specialty:**

**Most recent physical exam and purpose:**

**Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:**

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

☑ * **By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

## Dental Information

**How would you rate the condition of your mouth?**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Previous Dentist name and how long you have been a patient there:**

_____

_____

**Date of most recent dental exam:** _____ **Date of most recent dental x-rays:** _____

**I routinely see my dentist every:**

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**What is your immediate concern?**

_____

_____

**Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)** _____

**Personal History, Check all that apply:**

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

**Smile Characteristics, Check all that apply:**

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

**Bite and Jaw Joint, Check all that apply:**

☐ You have problems with your jaw joint
☐ You have any problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench you teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

**Tooth structure, Check all that apply:**

☐ Cavities within past 3 years
☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth
☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth
☐ Any teeth with grooves, notches, chips, a cracked filling or pain
☐ Food gets caught between any teeth

**Gum and Bone, Check all that apply:**

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experienced a burning sensation in your mouth

**If any of the checked boxes need further explanation, please describe:**

## Dental Practice Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ * **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.**

## Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

☐ **By checking this box, I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices.**

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

Signature _____ **Date** _____

**Name and relationship to patient:**

_____

_____

Your initial examination with radiographs and a cleaning is considered treatment. The standard of care per the American Dental Association, recommends that radiographs be taken yearly to properly assess. In order for us to proceed you will need to give your consent.

I hereby give consent to the treating dentist to do all necessary treatment. I understand that I have been informed of all the risks and alternative treatment methods. I also understand that treatment is subject to change.

Signature _____ **Date** _____

**Response Date:** _____