Loyal DENTISTRY

www.loyaldentistry.com

***How did you hear about our office?_____

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name: _____ Middle Initial:_____

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ EXT:_____ Cell Phone:_____

Birth Date: _____ Soc Sec#: _____ Driver's Lic:_____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone:_____ EXT:_____ Cell Phone:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Soc Sec#:_____ Driver's Lic:_____

Email: _____ ◯ I would like to receive correspondences via email

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Primary Insurance Information

Name of Insured: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date: _____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip:_____

Rem Benefits:_____ Rem. Deduct:_____

Seconday Insurance Information

Name of Insured: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec#: _____ Insured Birth Date:_____

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip:_____

Rem Benefits:_____ Rem. Deduct:_____

DENTAL HISTORY

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

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. *Have you had an unfavorable dental experience?*	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking?	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS	YES	NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease) _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

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

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

Loyal
DENTISTRY

Cancellation and No-Show Policy

At Loyal Dentistry, we understand that life can get busy, and sometimes things come up that prevent you from attending your scheduled appointment. However, in order to provide the best care to all our patients, we kindly request that you notify us in advance if you need to cancel or reschedule your appointment.

1. Cancellation Notice:
We ask that you provide at least **48 hours' Notice** if you need to cancel or reschedule your appointment. This allows us to offer the time to another patient in need of care.

2. Late Cancellations / No-Shows:
If you fail to cancel your appointment within 48 hours or do not show up for your scheduled appointment, a **fee of $75** will be charged. This fee helps to offset the cost of reserving time for you.

3. Repeat Cancellations / No-Shows:
Frequent cancellations or no-shows may result in the need for a deposit to schedule future appointments or a review of our continued care relationship.

4. Emergencies:
We understand that emergencies happen. If you experience an emergency that prevents you from keeping your appointment, please contact us as soon as possible. We will do our best to accommodate you.

5. Special Circumstances:
If you are unable to make your appointment due to illness, family emergency, or other unforeseen circumstances, please communicate with us. We will review these on a case-by-case basis.

6. How to Cancel or Reschedule:
To cancel or reschedule, please contact the following:
Arcadia location: (626) 477-0934 or email at: Info@loyaldentistry.com
Duarte location: (626) 357-2254 or email at: duarte@loyaldentistry.com
We appreciate your understanding and cooperation. Thank you for choosing Loyal Dentistry!

Signature_____ Date_____

Loyal
DENTISTRY

624 W. Duarte Rd, #204, Arcadia, CA 91007
1217 Buena Vista St, #202, Duarte, CA 91010

Agreement on Financial Policy and Insurance Payment

We will make every effort to give you accurate information we receive from your dental insurance company (or companies in situations where you have coverage by more than 1 insurance) so you have an idea of how much insurance may pay and how much you will pay for your consultation, x-rays, treatment(s), etc. However, this is only an **ESTIMATE**. Sometimes, despite our very best efforts, insurance companies don't have accurate information in cases where you may have pending claims that your insurance company (companies) may not have received yet. Other times, insurance agents give inaccurate information.

Please acknowledge the following:

I, _____ completely understand that the financial information regarding how much insurance pays and how much I have to pay is **ONLY** an **ESTIMATE**. After my dental insurance pays their portion, I may owe money or Loyal Dentistry may owe me money. If I owe money, I will pay the balance as soon as possible, but not later than 1 month. If Loyal Dentistry owes me money, Loyal Dentistry will send me a check as soon as possible, but not later than 1 month.

Signed: _____ Date: _____