



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

Last Name			First Name	Middle Name	Appointment date:
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:
- | | |
|---|---|
| <input type="checkbox"/> Angina (chest pains) Frequency _____ | <input type="checkbox"/> Rheumatic Fever (date) _____ |
| <input type="checkbox"/> Heart Attack (date) _____ | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Surgery (date) _____ | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Congenital Heart lesions |
| <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Pressure, if known _____ | |
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
- | | |
|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Local anesthetics |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Novocaine |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Xylocaine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous oxide |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Epinephrine |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Other pain medications: _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Any other drug allergies? _____ |
| <input type="checkbox"/> Other antibiotics: _____ | |

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
<input type="checkbox"/> Heart Medication	_____	_____	_____	_____
<input type="checkbox"/> Blood Pressure Medication	_____	_____	_____	_____
<input type="checkbox"/> Cholesterol lowering	_____	_____	_____	_____
<input type="checkbox"/> Insulin	_____	_____	_____	_____
<input type="checkbox"/> Nitroglycerine	_____	_____	_____	_____
<input type="checkbox"/> Blood Thinner Medication	_____	_____	_____	_____
<input type="checkbox"/> Antibiotics	_____	_____	_____	_____
<input type="checkbox"/> Sedatives	_____	_____	_____	_____
<input type="checkbox"/> Tranquilizers	_____	_____	_____	_____
<input type="checkbox"/> Anti Depressants	_____	_____	_____	_____
<input type="checkbox"/> Pain Medication	_____	_____	_____	_____
<input type="checkbox"/> Cortisone (Steroids)	_____	_____	_____	_____
<input type="checkbox"/> Thyroid	_____	_____	_____	_____
<input type="checkbox"/> Birth Control Pills	_____	_____	_____	_____
<input type="checkbox"/> Over Counter Medications	_____	_____	_____	_____
<input type="checkbox"/> Medicinal Patches	_____	_____	_____	_____
<input type="checkbox"/> 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: _____

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

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



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)

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

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: _____

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