



*Dental Wellness Center*

**Robert P. McBride, D.D.S., M.A.G.D**

# Patient Information

**Dental Wellness Center**  
5406 E. Village Road  
Long Beach, CA, 90808

(562) 421-3747  
www.LongBeachHolisticDentist.com  
leanne@rpm dentistry.com

## Patient Details

\_\_\_\_\_ Pronunciation: \_\_\_\_\_  
 \_\_\_\_\_  
 Last Name First Name Middle Name  
 I prefer to be called: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Residence Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Residence Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email ID: \_\_\_\_\_  
 If less than one year, previous address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License No. \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Spouse Details

Marital Status: \_\_\_\_\_ Spouse SS# \_\_\_\_\_  
 Name of Spouse: \_\_\_\_\_  
 Last First Middle  
 Spouse's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Relative's Details

Name of nearest relative not living with you: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Who is legally responsible, if other than the patient? \_\_\_\_\_  
 Last Name First Name Middle Name  
 Relationship to patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 How did you find out about the Dental Wellness Center? \_\_\_\_\_

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

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](http://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: \_\_\_\_\_



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       | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Heart attack        | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| High blood pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Stroke              | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Low blood pressure  | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Diabetes            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |

- |                |                                 |                                 |
|----------------|---------------------------------|---------------------------------|
| Cancer         | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Pre-term birth | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Gum disease    | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Tooth loss     | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |
| Dentures       | <input type="checkbox"/> Mother | <input type="checkbox"/> Father |



# Medical Health History

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## Provider Information

Family Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Date of last complete physical: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # with Area Code: \_\_\_\_\_

Additional Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # with Area Code: \_\_\_\_\_

Additional Physician or Health Provider, such as Chiropractor, Naturopath, Homeopath, Acupuncturist, etc.  
 Date of last visit: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # with Area Code: \_\_\_\_\_

\_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # with Area Code: \_\_\_\_\_

\_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # with Area Code: \_\_\_\_\_

## Please check areas that apply to you

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> # of drinks daily? _____	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Smoker
<input type="checkbox"/> Angina	<input type="checkbox"/> Fatigue Easily	<input type="checkbox"/> Nervousness /Depression	<input type="checkbox"/> Snore or gasp for air during sleep
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Periodontal Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Artificial Joints, Plates, Screws	<input type="checkbox"/> Heart Lesions	<input type="checkbox"/> Prophylactic antibiotics before cleaning or dental treatment	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation (Head / Neck)	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Recreational Drugs, such as marijuana, stimulants, depressants that may have a fatal with local anesthetics or other common dental medications?	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis: A B C	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hypoglycemia		<b>Women Only</b>
<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Jaundice		<input type="checkbox"/> Birth Control
<input type="checkbox"/> Diabetes/Prediabetes	<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Nursing
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Leukemia		<input type="checkbox"/> Pregnant: <i>Delivery Date</i>
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Liver Disease		_____

Are currently being treated for any of the above conditions?  Yes  No Which one(s)? \_\_\_\_\_

If being treated for another condition, please describe: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

Have you  gained  or lost weight within the last year? If so, How much? \_\_\_\_\_

Please check if you have any of the following drug allergies? \_\_\_\_\_

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Latex         | <input type="checkbox"/> Percodan        |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Anesthetic    | <input type="checkbox"/> Penicillin      |
| <input type="checkbox"/> Darvon       | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Antibiotics     |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa         | <input type="checkbox"/> Other Allergies |

Please list other allergies.

Please check if you have ever taken any of the following drugs \_\_\_\_\_

- |                                  |                                   |                                 |   |                                   |
|----------------------------------|-----------------------------------|---------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Fosamax | <input type="checkbox"/> Didronel | <input type="checkbox"/> Zometa | <input type="checkbox"/> Boniva         | <input type="checkbox"/> Phen Fen |
| <input type="checkbox"/> Aredia  | <input type="checkbox"/> Actonel  | <input type="checkbox"/> Skelid | <input type="checkbox"/> Biphosphonates |                                   |

Please list ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please name the pharmacy you use: \_\_\_\_\_

City: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you taking vitamins; food supplements; herbal preparations? Please list.

\_\_\_\_\_  
\_\_\_\_\_

Please feel free to offer any dental or medical information below that would assist us in getting to know you better

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sleep Disordered Breathing is highly prevalent in the U.S. population. This brief survey has been quite useful in discovering whether this possibility exists.**

**Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?**

- |                                |                                    |                                      |                                  |
|--------------------------------|------------------------------------|--------------------------------------|----------------------------------|
| <b>No chance of dozing = 0</b> | <b>Slight chance of dozing = 1</b> | <b>Moderate chance of dozing = 2</b> | <b>High chance of dozing = 3</b> |
|--------------------------------|------------------------------------|--------------------------------------|----------------------------------|

- |  |  |
|--|--|
| _____ Sitting and Reading  | _____ Lying down to rest in the afternoon if conditions permit |
| _____ Watching TV  | _____ Sitting and talking to someone                           |
| _____ Sitting inactive in a public place, ie... theater or a meeting | _____ Sitting quietly after lunch without alcohol              |
| _____ As a passenger in a car for an hour without a break            | _____ In a car, while stopped for a few minutes in traffic     |

\_\_\_\_\_ TOTAL SCORE

Is there a disease or condition not listed above that you think I should know of?  Yes  No If Yes, what?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify The Dental Wellness Center of any changes. I understand that if I withhold information regarding allergies, medical conditions, medications, or supplements, I agree not to hold The Dental Wellness Center or its employees liable in the event of death or injury. Authorization is given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature (Patient / Guardian)

Date

Dentist Signature