Gabrie Dental Center
Dr. Linda Hu
212 S. Atlantic Blvd., 103
Los Angeles, CA 90022

PATIENT REGISTRATION AND MEDICAL HISTORY

Email : _____

Date _____ (PRINT PLEASE) Home Phone _____

Patient _____
Last Name *First Name* *Initial* *Preferred Name*

Street Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birth Date _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply)

☐ Heart Murmur	☐ Epilepsy	☐ Special Diet
☐ High Blood Pressure	☐ Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous Problems	☐ Psychiatric Care	☐ AIDS/HIV
☐ Radiation Treatment	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Artificial Heart Valves or Joints	☐ Allergies to Anesthetics	☐ Stroke
☐ Recent Weight Loss	☐ Allergies to Medicine or Drugs	☐ Ulcer
☐ Back Problems	☐ General Allergies	☐ Venereal Disease
☐ Diabetes	☐ Blood Disease	☐ Chemical Dependency
☐ Respiratory Disease	☐ Arthritis	☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have committed while filling out this form.

Date _____ Signature _____

(TURN OVER)

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ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____, do hereby request
Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

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GENERAL DENTISTRY INFORMED CONSENT

Patient Name _____

I understand that I am having the following work done and authorize the treatment as indicated.

X-rays _____ Exam _____ Cleaning _____ Initials _____

1. **WORK TO BE DONE** — I understand that I am having the following work done: Fillings _____ Bridges _____
   Crowns _____ Extractions _____ Impacted Teeth Removed _____ Root Canals _____
   Other _____
   Initials _____

2. **DRUGS AND MEDICATIONS** — I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
   Initials _____

3. **CHANGES IN TREATMENT PLAN** — I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions necessary, after informing me of said changes.
   Initials _____

4. **REMOVAL OF TEETH** — Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, opening into sinus, loss of feeling in my teeth, lips, tongue and surrounding tissues (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand that complications may require further treatment by a specialist or even hospitalization.
   The cost is my responsibility. Initials _____

5. **CROWNS, BRIDGES AND CAPS** — I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation. I further understand that my gingiva (gums) may be sore until healing time has elapsed and that during this healing time my gingiva around the tooth being capped may shrink (recession), sometimes making the tooth look longer than the natural tooth.
   Initials _____

6. **DENTURES, COMPLETE OR PARTIAL** — I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, tooth placement and color) will be the teeth in wax “try-in” visit. I understand that most dentures require relining approximately 3-12 months after initial placement. The cost for this procedure is not included in the initial dental fee.
   Initials _____

7. **ENDODONTIC TREATMENT (ROOT CANAL)** — I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (epicoectomy).
   Initials _____

8. **PERIODONTAL LOSS (TISSUE & BONE)** — I understand that I may have a serious condition causing gum and bone inflammation and/or loss and that it can lead to the loss of my teeth. Alternate treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
   Initials _____

I understand that dentistry is not an exact science and reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Signature _____ Date _____

Doctor _____ Witness _____