Lasting Impressions Dental Spa
16101 Ventura Blvd Suite 350
Encino, CA 91436
(818) 751-5100

Patient Information

Date ___________

Personal Information

Last Name _____________________ First Name ______________________ Initial ______ Birth date ____/____/_____
Address _____________________________________ City _______________ State ______ Zip Code ______________
Home Phone _______________ ___Cell Phone ____________________ Email _______________________________
Marital Status ____________Social Security Number ______/_____/_______ Drivers License Number _______ State ___
Person to contact in case of emergency: ___________________ Phone Number ________________________________

Whom may we thank for referring you?

Insurance Information

Employer ___________________ Name of Insurance ___________________ Insured Name _____________________
Birth date ____/_____/_____ Identification Number ________________ Social Security Number _________________
Group Number ________________ Insurance Phone Number _______________

Dental History and questionairre

Reason for today's visit ____Last Dental Exam _______________________
Date of last dental x-rays _____________________ How often do you brush? ___________________________________
How often do you floss? ____________________________
How would you rate your last dental experience? ____
What would you like to change about your smile? ____
What are your expectations of your teeth in the next five years? ____
How can we make your dental experience a pleasant one? ____
Are you happy with the shape and size of your teeth? ____

Medical History

Are you seeing a Physician for any current medical conditions? O YES O NO Do you smoke? O YES O NO
If so, Please provide physician name and phone number ____
Please list any/all medications you are currently taking: ____
Any allergies: ____
(Women) Are you pregnant? O YES O NO Nursing? O YES O NO
Do you have any of the following? O YES O NO **If none please skip to next page.**

O Aids
O Anemia
O Arthritis, Rheumatism
O Artificial heart valves
O Artificial Joints
O Asthma
O Back Problems
O Blood Disease
O Cancer
O Chemical Dependancy
O Chemotherapy
O Circulatory Problems
O Cortisone Treatments
O Cough, Persistent
O Cough, Blood
O Diabetes
O Epilepsy
O Fainting Spells
O Glaucoma
O Headaches
O Heart Murmur
O Heart Problems
Describe __________
O Hemophilia
O Hepatitis Type _____
O High Blood Pressure
O HIV Positive
O Jaw Pain
O Kidney Disease
O Liver Disease
O Mitral Valve Prolapse
O Pacemaker
O Psychiatric Care
O Radiation Treatment
O Respiratory Disease
O Rheumatic Fever
O Scarlet Fever
O Skin Rash
O Shortness of Breath
O Stroke
O Swelling of feet and ankles
O Thyroid Problems
O Tobacco Habit
O Tonsilitis
O Tuberculosis
O Venereal Disease

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me/patient during the period of such dental care to the third party payers (insurance) and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance enefits otherwise payable to me. I understand that Insurance coverage is just an estimate, and not a guarantee of benefits. I understand that if the dental practice's attempt to receive payment from the insurance is not succesful after 90 days, I am responsible for the payment of the services.

Print Name ________________________________Signature _____________________________Date _______________

Video Surveilance Consent and Acknowledgement

I understand that there is a complete surveilance system installed at Sargon Dental Implants/ Lasting Impressions Dental Spa. It was explained to me that there are no cameras in private areas such as the restrooms, locker rooms, and rest areas. One of the purpose of the cameras is to provide added security in the premises. The video content is stored in a safe place for about 30-60 days. The video content is for private viewing of the owners and in no way will be released to any other party without the written consent of the parties.

I understand that I may ask more questions about the Video surveillance system. I'll be given a copy of this Consent for my records if requested.

Print Name ________________________________Signature _____________________________Date _______________

Cancellation Policy

Here at Lasting Impressions Dental Spa, our ultimate goal is to provide you with the finest care in the industry. In order to provide you with the best of service we reserve chair time especially for you. Therefore, if you need to cancel or reschedule an appointment we ask that you give us at least 48 hours notice. We understand emergencies arise but ask that if you anticipate a conflict of schedule to inform us in a timely manner. If you fail at notifying us of a change of schedule there is a $75.00 broken appointment fee that will be applied per hour reserved.

I have read and understand the cancellation policy.

Print Name ________________________________Signature _____________________________Date _______________

We know you have many choices when it comes to your dental care, we thank you for choosing Lasting Impressions Dental Spa.