PALM DESERT DENTIST
Cosmetic, Restorative & Implant Dentistry
Robert McLachlan, Jr., DDS, MS Reena Patel, DDS

PATIENT INFORMATION

Patient Name:_____Date: _____
Last, First MI (Preferred Name)

Social Security #_____ Birth Date_____ Gender M / F

Phone (Home) _____(Work)_____ Ext_____(Cell)_____

Address_____
Street City State Zip Code

Out of State Address_____
Street City State Zip Code

Email Address_____

Occupation_____Employer_____ Best time to call_____

Marital Status ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouse's or Parent's Name _____Relationship_____

In case of Emergency Contact _____ Phone_____

INSURANCE INFORMATION

NONE_____

Primary:
Name of subscriber _____ Birth date _____/_____/_____ Social Security # _____
Relationship to Patient: _____ Home Ph. (_____) _____ Work Ph. (_____) _____
Name of Employer: _____
Address City State ZIP
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address: _____
Address City State ZIP

Secondary:
Name of subscriber _____ Birth date _____/_____/_____ Social Security # _____
Relationship to Patient: _____ Home Ph. (_____) _____ Work Ph. (_____) _____
Name of Employer: _____
Address City State ZIP
Insurance Company: _____ Group # _____ Union or Local # _____
Ins. Company Address: _____
Address City State ZIP

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____
Friend_____Internet_____ Television_____ Phone Book_____ Other_____

Do you live here? ☐Full time ☐Seasonal from_____ to _____

In our efforts to be efficient, conscious of the world we live in, and supportive of protecting our planet we communicate through email and text messages to our patients regarding appointments. Which do you prefer we use to contact you?
☐Email ☐Text message?

CONFIDENTIAL HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- ☐ Cancer Of _____
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Tumors
- ☐ HIV
- ☐ Blood Disease
- ☐ Diabetes (Type)____
- ☐ Excessive Bleeding
- ☐ Artificial Joints_____ (Date) _____
- ☐ Arthritis
- ☐ Kidney Problems
- ☐ Rheumatic Fever
- ☐ Mitro Valve Prolapse
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Blood Thinners
- ☐ Jaundice / Cirrhosis
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Dizziness
- ☐ Respiratory Problems
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Sinus Problems
- ☐ Head Injuries
- ☐ Headaches
- ☐ Ulcers
- ☐ Fainting
- ☐ Venereal Disease
- ☐ Stroke: Date_____
- ☐ Smoke/Tobacco Use
- ☐ Metals Allergy
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Allergies_____ _____

Women:

- ☐ Pregnant Due date:_____

Do you have or have had any disease, condition, or problems not listed? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone:_____

List Current Medications _____

DENTAL HISTORY:

- Have you ever taken **Biphosphonate** (for Osteoporosis or Bone Cancer)? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

Date of Last Dental Visit:_____ Reason for this visit: _____

Last Cleaning _____Last Full Mouth X-Ray _____ Previous Dentist Name _____

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or cold	Yes	No
Sweets	Yes	No
Biting Or Chewing	Yes	No

DO YOU:

Have gums that bleed or hurt?	Yes	No
Clench Or Grind Your Teeth?	Yes	No
Have any loose or missing teeth?	Yes	No
Have any broken teeth or tooth restorations?	Yes	No
Have tired jaws when you awaken?	Yes	No
Have difficulty in opening or closing your mouth wide or yawning?	Yes	No
Have pain (Ear, Jaw Joint, Side of Face)?	Yes	No
Do you feel or hear a clicking, popping or cracking noise from either jaw joint?	Yes	No
Have your jaw ever lock open or closed?	Yes	No
Have any change in how you bite?	Yes	No
Have mouth odors or bad taste?	Yes	No

HAVE YOU EVER HAD:

Orthodontic Treatment	Yes	No
Periodontal Root Planning/Scaling	Yes	No
Periodontal Surgery	Yes	No
Your Teeth Ground or The Bite Adjusted	Yes	No
A Serious Injury To The Mouth	Yes	No

Please describe_____

_____

Parents that had gum disease or tooth loss?	Yes	No
Nervousness about being in a dental office or having dental treatment?	Yes	No
An upsetting dental experience?	Yes	No

Please describe _____

Would you prefer Nitrous Oxide or Oral Sedation when you have dental treatment?	Yes	No

Are you satisfied with your teeth's appearance? Yes No
Would you like to improve the appearance of your teeth? Yes No
Is there anything else about having dental treatment you would like us to know? Yes No
Please describe_____

Patient Name:_____

RESPONSIBLE PARTY

CONSENT FOR SERVICES: To the best of my knowledge, all of the preceding answers and Information provided are true and correct. If I ever have any change in my health, I will Inform Palm Desert Dentist at the next appointment without fall.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs Incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All dental and surgical procedures are to be paid in full at the time of service. All sedation (anxdolysis) appointments require a 1 week cancellation notice. You will need to make a pre-treatment appointment at least 1 week prior to your sedated treatment appointment to receive your prescriptions, pre-op and post-op Instructions, sign consents, and make your payment for treatment. This appointment is mandatory. It is not ethical for us to have you sign consents or take money from you on the day of your sedated treatment appointment because when you arrive to our office you will already have sedation medication in your body. This appointment should take 30 minutes. There is no charge for this visit.

Insured patients: You are financially responsible for any and all charges at Palm Desert Dentist office. No matter what your insurance pays.

This office will help prepare the patients insurance forms or assist in making collections from Insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an Insurance company. You are responsible for payment in full. Any Insurance benefits quoted are estimated your actual Indemnity may be less. If we are a contracted provider with your Insurance we will accept your copayment at time of service. You are responsible for all amounts not covered by your Insurance. If we are NOT contracted with your Insurance company, you will pay for treatment in full and your Insurance will reimburse you directly. For all patients with Insurance, we will submit claims and all necessary documentation as required by your insurance company as a courtesy to you, but all payment responsibility lies with the patient Understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. Any balance remaining on an account for over 30 days will be charged a finance charge of 18%. We offer a 5% prepayment courtesy If you pay with cash or check for treatment plans that are over $5000.00 when you pay for the complete treatment plan at your pre-treatment appointment.

By signing below I acknowledge that I am here for treatment of my own free will and request my choice of treatment be done to correct the dental conditions that I have presented to Palm Desert Dentist. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of sald services to sald Doctor, or his assignee, at the time sald services are rendered. I further agree that the reasonable value of sald services shall be as billed unless objected to, by me, In writing, within the time for payment thereof. I further agree that a walver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees If sult were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and treatments. I have read the above conditions of treatment and payment and agree to their content

Should the need arise, I ☐ **Agree** ☐ **Do Not Agree** to give my permission to discuss any or all of my treatment with family members such as (please circle as many that apply):

Spouse Parent(s) Significant Other Guardian Grandparents Aunt / Uncle Children Care Giver Sister / Brother
Other _____

WE RESERVE THE RIGHT TO CHARGE FOR CONFIRMED APPOINTMENTS THAT ARE BROKEN WITHIN 24 HOURS

Signature of patient, parent or guardian _____ Date_____

_____

FOR OFFICE USE ONLY:

Initial Blood Pressure Record:_____ Pulse: _____Taken by _____

Note Changes Below:	Patient Signature:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name:_____