Neil S. McLeod, BDS, LDS, RCS, DDS

DENTISTRY THAT LASTS - QUALITY THAT COUNTS

9201 W Sunset Blvd, Suite 715
West Hollywood, CA 90069
drneilmcleod@yahoo.com
http://www.drneilmcleod.com/
Phone: (310) 275-5379 Fax: (310) 275-6854

Date _____ MM/DD/YYYY

PATIENT INFORMATION

■Mr. ■Mrs. ■Ms. ■Dr. Name _____ FIRST NAME _____ M.I. _____ LAST NAME

Sex: ■M ■F ■O Birth Date _____ MM/DD/YYYY Soc. Sec. # _____ Driver's Lic.#/I.D.# _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP

Home Phone _____ Cell Phone _____

Email _____ Employer _____

Occupation _____ Bus. Phone _____

Bus. Address _____ STREET _____ CITY _____ STATE _____ ZIP

Former Dentist _____ FIRST NAME _____ LAST NAME Physician _____ FIRST NAME _____ LAST NAME

Marital status: ■Married ■Divorced ■Widowed ■Single ■Legally Separated ■Long Term Partner ■Minor

Spouse _____ FIRST NAME _____ LAST NAME Phone _____

Emergency contact _____ FIRST NAME _____ LAST NAME Phone _____ Relation _____

RESPONSIBLE PERSON

■Self (If self, skip this section) ■Other _____ RELATION Name _____ FIRST NAME _____ LAST NAME

Sex: ■M ■F ■O Birth Date _____ MM/DD/YYYY Soc. Sec. # _____ Driver's Lic.#/I.D.# _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ Bus. Phone _____

REFERRAL INFORMATION

Who referred you to us? ■Dentist ■Medical Dr. ■Relative ■Friend ■Former Patient ■Other _____

Name _____ FIRST NAME _____ LAST NAME Phone _____

If not referred, how did you find us? ■Internet Search ■Our Website ■Advertisement ■Yellow Pages ■Other _____

PRIMARY INSURANCE

Insured Party _____ FIRST NAME _____ LAST NAME Sex: ■M ■F ■O Soc. Sec. # _____

Relation _____ Birth Date _____ MM/DD/YYYY Phone _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP

Employer _____ Bus. Phone _____

Bus. Address _____ STREET _____ CITY _____ STATE _____ ZIP

Insurance Company Name _____ Ins.Co.Phone _____

Ins.Co.Adress _____ STREET _____ CITY _____ STATE _____ ZIP

I.D. # _____ Plan _____ Group # _____ Group Name _____

ADDITIONAL INSURANCE

Insured Party _____ FIRST NAME _____ LAST NAME Sex: ■M ■F ■O Soc. Sec. # _____

Relation _____ Birth Date _____ MM/DD/YYYY Phone _____

Address _____ STREET _____ CITY _____ STATE _____ ZIP

Employer _____ Bus. Phone _____

Bus. Address _____ STREET _____ CITY _____ STATE _____ ZIP

Insurance Company Name _____ Ins.Co.Phone _____

Ins.Co.Adress _____ STREET _____ CITY _____ STATE _____ ZIP

I.D. # _____ Plan _____ Group # _____ Group Name _____

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FIRST NAME _____ LAST NAME _____

HEALTH HISTORY

Reason for today's office visit _____ Yes No

Are you in good health? ☐ ☐

Height _____ Weight _____

Have there been any changes in your general health in the past year? ☐ ☐

If so, describe _____

Are you under the care of a physician? ☐ ☐

If so, describe _____ Date of last visit _____

Have you had any operation or been hospitalized in the past five years? ☐ ☐

If so, describe _____

Have you, or a family member, had any unusual or serious reactions to general or local anesthesia? ☐ ☐

YOU HAD OR CURRENTLY HAVE..

- ☐ Rheumatic fever
- ☐ Damaged heart valves / Mitral valve prolapse
- ☐ Heart murmur
- ☑ High blood pressure
- ☑ Low blood pressure
- ☑ Chest pain / Angina
- ☑ Heart attack(s)
- ☑ Irregular heart beat
- ☑ Cardiac pacemaker
- ☑ Heart surgery
- ☑ Bronchitis, chronic cough
- ☑ Asthma
- ☑ Hay fever / Sinus problems
- ☑ Snoring / Sleep apnea
- ☑ Difficult breathing / Other lung trouble
- ☑ Tuberculosis
- ☑ Emphysema
- ☑ Aids
- ☑ Blood transfusion
- ☑ Blood disorder such as anemia
- ☑ Contact lenses
- ☑ Bleeding tendency / Abnormal bleed
- ☑ Hepatitis, jaundice, or liver disease
- ☑ Infectious mononucleosis
- ☑ Gallbladder trouble
- ☑ Fainting spells
- ☑ Convulsions
- ☑ Stroke
- ☑ Thyroid trouble
- ☑ Diabetes
- ☑ Low blood sugar
- ☑ Kidney trouble
- ☑ Swollen ankles, arthritis or joint disease
- ☑ Stomach ulcers
- ☑ Contagious diseases
- ☑ Sexually transmitted diseases
- ☑ Delay in healing
- ☑ High cholesterol
- ☑ Eye disease / Glaucoma
- ☑ Epilepsy
- ☑ Problems with your immune system
- ☑ (possibly from medication, surgery, etc.)
- ☑ A tumor or growth
- ☑ Radiation therapy / Chemotherapy
- ☑ Chronic fatigue / Night sweats
- ☑ A history of drug abuse
- ☑ A history of alcohol abuse
- ☑ Mental health problems
- ☑ Valve replacement / Vascular graft
- ☑ Prosthetic joint / Implant
- ☑ Malignant hyperthermia
- ☑

FOR WOMEN ONLY:

- ☑ Pregnant
- ☑ Nursing
- ☑ Taking birth contrail pills
- ☑ Expected delivery date:
- ☑ Note: Antibiotics (such us penicillin) may alter the
- ☑ effectiveness of birth contrail pills. Ask your physi-
- ☑ cian / gynecologist for assistance regarding other methods of birth control.

MEDICATION - You are now taking...

- ☐ Insulin
- ☐ Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Gingko Biloba)
- ☐ Diet pills
- ☐ Pain killers (including aspirin)
- ☐ Muscle relaxers
- ☐ Any bone density medications (Aredia, Zometa, Fosamax, Actonel)
- ☐ Tranquilizers
- ☐ Sleeping pills
- ☐ Antidepressants
- ☐ Stimulants

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products): _____

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ALLERGIES - You are allergic to, or had a reaction to

- ☐ Local anesthetic (e.g. novocaine)
- ☐ Penicillin
- ☐ Other antibiotics
- ☐ Sulfa Drugs
- ☐ Tranquilizers
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Sulfites
- ☐ Latex
- ☐ Soy
- ☐ Eggs/Yolk

Please list any other allergies: _____

DENTAL INFORMATION

	Yes	No
Are you in pain?	☐	☐
If so, for how long?		
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
If so, describe _____		
Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☐
If so, describe _____		

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ A removable dental appliance
- ☐ Blisters / Sores in or around the mouth
- ☐ Prolonged bleeding from an injury / Extraction
- ☐ Resent infections or sore throat
- ☐ Difficulty closing jaw
- ☐ Difficulty opening jaw
- ☐ Lost / Broken filling(s)
- ☐ Teeth grinding / Clenching
- ☐ Toothache
- ☐ Broken / Chipped tooth
- ☐ Gum disease
- ☐ Pain in jaws when eating
- ☐ Loose / Shifting teeth
- ☐ Food caught between teeth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Burning tongue / Lips
- ☐ Frequent headaches
- ☐ Ringing in ears
- ☐ Swelling / Lumps in mouth
- ☐ Other

Sensitive to:

- ☐ Hot
- ☐ Coid
- ☐ Sweets
- ☐ Biting
- ☐ Sour

OTHER

	Yes	No
Is there any condition concerning your health that the doctor should be told about?	☐	☐
If so, describe		
Do you wish to speak to the doctor privately about anything?	☐	☐
Do you bruise easily?	☐	☐
Are you immunosuppressed? (possibly from transplant surgery, etc.)	☐	☐
Do you use chewing tobacco?	☐	☐
Do you smoke?	☐	☐
Are you on dialysis?	☐	☐
Are you on a diet?	☐	☐

Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthetic Problems ☐ Tuberculosis ☐ Hepatitis

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INFORMED DENTAL CONSENT

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and treatment. I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment 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. I also understand that no other dentist or corporate entity, other than the treating dentist, is responsible for my dental treatment.

DENTAL X-RAY AND PHOTO CONSENT

I hereby authorize above-mentioned dentist or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by dentist to make a thorough diagnosis of my, or my dependent's, dental needs. Further, I authorize this practice to take my picture for my electronic health record.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the treatment period to the third party payors and/or other health practitioners.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize and request my insurance company to pay directly to the above-mentioned provider or provider's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to this office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

By signing below, I certify that I have read and understand all questions set forth in this form and agree with all terms stated above. I acknowledge that all questions in this form have been answered to my satisfaction and to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate treatment. I will not hold my dentist or any other member of his / her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: X _____ Date: _____
Signature of Patient or Personal Representative (Parent or Guardian if Minor) MM/DD/YYYY