

LIBBY DENTAL

Inspiring Health & Happiness

Dr. Landon Libby

2405 Morena Blvd, San Diego CA 92110 • (619) 276-6884 • www.Libby.dental

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME _____ Preferred Name _____

Married Single Divorced Separated Widowed

Male Female Social Security No. _____ - _____ - _____ Birthdate _____ / _____ / _____

Mailing Address _____ Home Phone (____) _____ - _____

City _____ State _____ Zip Code _____

Cell (____) _____ - _____ Fax (____) _____ - _____ Email _____

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate _____ / _____ / _____ Social Security No. _____ - _____ - _____

Patient Occupation _____ Employer _____ Work Phone (____) _____ - _____

Spouse Occupation _____ Employer _____ Work Phone (____) _____ - _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
Employee's S.S. No. _____ - _____ - _____	Employee's S.S. No. _____ - _____ - _____

Person responsible for payment: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. (____) _____ - _____ Work Ph. No. (____) _____ - _____

Relationship to Patient _____

DENTAL HISTORY

Chief dental concern: _____

- Are you nervous about having dental treatment? Yes No
- Have you ever had a bad dental experience? Yes No
- Do you have difficulty or pain when opening (yawning)? Yes No
- Does your jaw get stuck, locked or "go out"? Yes No
- Difficulty / pain when chewing, talking, or using your jaws? Yes No
- Teeth? Yes No
- Do you have noises in your jaw joints? Yes No
- Pain about the ears, temples or cheeks? Yes No
- Does your bite feel uncomfortable or unusual? Yes No
- Have you had a recent injury to your head / jaw? Yes No

- Have you been treated for a jaw joint problem? Yes No
- Do your teeth ever feel loose? Yes No
- Does food catch in-between your teeth? Yes No
- How often do you brush? _____ Floss? _____ Yes No
- Any difficulty chewing your food? Yes No
- Have you ever had periodontal disease? Yes No
- Are your teeth sensitive to cold / heat / etc? Yes No
- Have you ever been premedicated for dental work? Yes No
- Do you have frequent Headaches? Yes No
- Are you happy with the way your smile looks? Yes No
- If not, what would you change? _____

HEALTH HISTORY

- Are you having any pain or discomfort at this time? Yes No
- Do you smoke or use tobacco in any form? Yes No
- Have you been hospitalized in the past 2 years? Yes No
- Have you been under the care of a medical doctor during the past 2 years? Yes No
- Physician Name _____
- Address _____ Phone: _____

- Are you currently taking any medications / drugs? Yes No
- If yes, please list: _____
- List Medications: _____
- _____
- _____
- Women: Are you pregnant? Yes No
- Please list any serious medical condition(s) that you have/had: _____

Please check "Yes or No" to the following conditions:

- | | | | |
|--|--|---|--|
| <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease / Attack / Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> <input type="checkbox"/> High / Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion / Anemia</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise Easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease / Yellow Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Failure/Disfunction</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> X-ray / Cobalt Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Cosmetic Surgery</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema / Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough / Tuberculosis (TB)</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis / Rheumatism</p> <p><input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> A.I.D.S. / H.I.V.</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis: A B C (circle one)</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints (Hip, Knee)</p> <p><input type="checkbox"/> <input type="checkbox"/> Scarlet Fever</p> | <p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters / Cold Sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting / Dizzy Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever / Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies / Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol Addiction</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood thinner</p> <p><input type="checkbox"/> <input type="checkbox"/> Splenectomy</p> |
|--|--|---|--|

Are you allergic to or have you reacted adversely to the following?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals / Jewelry | <input type="checkbox"/> Local/Dental Anesthetic |

Are you aware of being allergic to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give permission to Dr. Landon Libby and his staff to use any photos taken for lecturing and continuing education purposes.

Signature _____ Date _____

Medical History Update

(For Office Use Only)

Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____
Date _____	Comments _____	Date _____	Comments _____



PATIENT FINANCIAL AGREEMENT

Dr. Landon Libby

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PATIENT _____ DATE _____

Thank you for choosing our office for your dental care. Dental treatment is an excellent investment in your medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and assist you regarding your treatment needs.

Insurance? We bill and accept payment from most dental insurances. As a courtesy, claims are filed electronically in a timely manner including all information required to receive the maximum benefits *allowed* for the services rendered. Plan details and coverage is between you and the insurance company. As such, we can make no guarantee of estimated coverage or payment.

Estimated Professional Fee \$ _____

NOTES:

Estimated Insurance Benefit \$ _____

Down Payment \$ _____

Patient will be billed for any remaining balance due.

Payment Options

- Plan A: Cash, Check, Debit Card
- Plan B: Visa, and MasterCard
- Plan C: Short and long term financing available through CareCredit financing company.
- Plan D: Upon completion of a Credit Card Authorization Form, we will charge your credit card, as authorized by you.

I have chosen Payment Plan ___ above. I understand that my dental plan/s is strictly a contract between my insurance carrier and myself and that my insurance coverage may vary. As such, I agree to be ultimately responsible for payment of all dental services rendered not paid by insurance within 60 days. Outstanding account balances over 60 days from date of service will accrue one percent (1%) interest per month, ten percent (10%) per year.

Signature of patient or authorized consent

Date

Signature of Financial Coordinator

Date

Fees quoted will be honored for (60 days) days from the date upon which this treatment plan is signed.