Paradise Dental Center

paradisedentalsaipan@gmail.com paradisedentalspa.com

PO Box 10001 | PMB 213 • Saipan, MP 96950 (670)234-4040

Welcome to Paradise!
Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Last Name _____

First _____ Middle _____ Nick Name _____

DOB _____ Married __ Single ___ Other ___

PO BOX/ Address _____ City _____ Zip _____

Home Phone _____ Cell _____ Work _____ Other _____

Email Address _____ Employer_____

How did you hear about Paradise Dental? _____

How would you like us to contact you? (Please check one) Text___ Call___ Email ___

Name of Dental Insurance _____

Main Subscriber Name _____ Employer _____

Emergency contact info:

Name _____ Relationship _____

Home_____ Cell _____ Work _____

Response Date: _____

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Medical & Dental History Form

Within the past year, have there been any changes in your general health?

_____

_____

WOMEN ONLY: Are you pregnant? ○ Yes ○ No

Please write down any medication(s) you are taking: _____

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Back Problems
- ☐ Codeine
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Penicillin
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Ulcers
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ HIV
- ☐ Jewelry
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Thyroid Problems
- ☐ Venereal Disease
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ Ibuprofen
- ☐ Kidney Disease
- ☐ Other
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Cephalospirins
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Januvia
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Tumors

Do you have any other health issues or allergies? If NONE, write none:

_____

_____

What is the reason for your dental visit today?

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

Response Date: _____

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What is the most important thing to you about your teeth? (Check all that apply.)

Just function - (example: I just want to be able to keep my teeth so I can eat a good steak!) _____

Just Cosmetic - (example: I just want to look good and have a great smile!) _____

Both Function AND Cosmetic _____

Other - _____

_____

What is the most important thing to you about your dentist or dental office:

_____

Do you wish your teeth were:
Whiter _____ **Straighter** _____**Neither** _____

On a scale of 1-4 (1 being the least and 4 being the most), which of these affect you the most when seeking dental treatment?
Pain _____**Fear** _____**Cost** _____**Time** _____
◯ Yes ◯ No

Policy

***All cancelled, missed and rescheduled appointments w/o 24hours notice are billable to you the patient at $25.00 per incident. _____ (Initials)**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ Date _____

Relationship to Patient: