Patient Information

Name: Last _____ First _____ Middle _____ Sex: Male ____ Female ____

Birth Date: _____ Social Security _____ E-mail _____

Phone: Home _____Work _____ Ext _____ Mobile _____

Preferred Method of Contact: Text Msg ___ E-mail ___ Phone ___

Address: _____

City: _____State: _____ Zip: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____State: _____ Zip: _____

Whom may we thank for referring you to our practice? _____

Emergency Contact: Name _____ Phone: _____

Insurance Information

Primary Insurance Plan: _____ Insurance Phone: _____

Insurance Address: _____

City: _____State: _____ Zip: _____

Insured's Name: _____ Insured's Birth Date: _____

Insured's Relationship to Patient: Self _____ Spouse _____ Child _____ Other _____

Insured's Member ID/SSN: _____ Group Number _____

Insured's Address: _____

City: _____State: _____ Zip: _____

Insured's Employer: _____

Employer Address: _____

City: _____State: _____ Zip: _____

Secondary Insurance Plan: _____ Insurance Phone: _____

Insurance Address: _____

City: _____State: _____ Zip: _____

Insured's Name: _____ Insured's Birth Date: _____

Insured's Relationship to Patient: Self _____ Spouse _____ Child _____ Other _____

Insured's Member ID/SSN: _____ Group Number _____

Insured's Address: _____

City: _____State: _____ Zip: _____

Insured's Employer: _____

Employer Address: _____

City: _____State: _____ Zip: _____

Medical History

Do you have, or have you had, any of the following?

☐ Abnormal Bleeding	☐ Anemia	☐ Arthritis	☐ Artificial Heart Valve
☐ Artificial Joint	☐ Asthma	☐ Back Problems	☐ Blood Disorders
☐ Cancer	☐ Chemotherapy	☐ Chest Pain	☐ Diabetes
☐ Dizziness/Fainting	☐ Emphysema	☐ Epilepsy or Seizures	☐ Excessive Bleeding
☐ Frequent Headaches	☐ Heart Attack/Failure	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis, Type ___	☐ Herpes	☐ High Blood Pressure	☐ HIV/ AIDS
☐ Kidney Disorders	☐ Liver Disorders	☐ Low Blood Pressure	☐ Lupus
☐ Osteoporosis	☐ Pacemaker	☐ Psychiatric Care	☐ Radiation Treatments
☐ Respiratory Disorders	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Skin Rash	☐ Stomach Disorders	☐ Stroke	☐ Thyroid Disorders
☐ Tuberculosis	☐ Tumors	☐ Venereal Disease (STD)	☐ *Pre-Meds Needed
Female Patients Only:	☐ Pregnant	☐ Breastfeeding	☐ Birth Control Pills

Please check if you're allergic to any of the following:

☐ Local anesthetics ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex ☐ Penicillin ☐ Seasonal
☐ Sulfa ☐ Other_____

Current health condition: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of personal physician: _____ Approximate date of last visit: _____

☐ Have you ever been hospitalized or had a major operation?
Please explain: _____

☐ Are you being treated by a physician now?
Please explain: _____

☐ Do you use tobacco?
☐ Do you use alcohol?
☐ Do you use controlled substances or recreational drugs?

Please list all medications, supplements, and/or vitamins:

_____

Please describe any other condition not listed above:

_____

Dental History

Main Reason for Your Visit _____

Your Previous Dentist_____ Date of Last Exam and X-rays _____

☐ Had an unfavorable dental experience	☐ Had complications from dental treatment	☐ Had bleaching
☐ Had any teeth removed	☐ Had Braces, orthodontic treatment	☐ Had cavities within last 3 years
☐ Had gum (periodontal) treatments	☐ Had bite appliance or nightguard	
☐ Problems with jaw joint	☐ Clenching or grinding teeth	☐ Problems with chewing
☐ Sensitivity to cold, hot, and/or sweet	☐ Gums bleed when brushing or flossing	☐ Noticed unpleasant taste or odor
☐ Bite nails, chew ice, or other oral habits	☐ Dry mouth	

☐ Is there anything you would like to change about appearance of your teeth?

_____

I certify that I have read and understand the above and that the information given on form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signed_____Relationship to Patient _____ Date: _____

☐ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

Office Policies

Appointment Policy

When we make your appointment, we are reserving the doctor's time for your particular needs. If you are unable to keep your appointment, please give us at least 48 hours' notice. This courtesy makes it possible for us to give your reserved time to another patient who may benefit from being seen sooner. There is a $50.00 charge for a cancellation or missed appointment, and repeated cancellations and missed appointments will result in loss of future appointment privileges.

We respect that your time is valuable; therefore we make every effort to see you at scheduled times. As a courtesy to our staff and other patients, please make every effort to be at our office on time. If you are late by 30 minutes or more, we may need to reschedule you for another date and time.

Contact Permission

Permission is granted to the doctors, the office staff, or their assigns to text-message, e-mail, or telephone, the patient or the party responsible to discuss matters related to patient information, insurance information, or theses terms and conditions for treatment.

Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have questions, please discuss them with our office.

Payment is due at the time of service. We understand the value of dental insurance to our patients, so as a courtesy, we will gladly file claims with insurance carriers (including all necessary documents regarding the need for treatment) on your behalf. All insurance claims are processed and submitted by our office on the day of visit, and payments should be returned within 4-6 weeks of submission. Since we incur the cost of providing patients with care at the time they undergo treatment, we encourage our patients to pay in full when possible either prior to or on the day that services are rendered and receive the insurance benefits themselves. We will accept assignment of benefits to our office as one form of payment. Patients are then responsible for whatever costs insurance do not cover. The patient portion will be estimated to our best ability, and the estimated amount is due on the day services are rendered. If the insurance pays the office less than we estimated, our patients will be billed the difference, and should we receive more, the difference can either be refunded, or applied to future care. If the dental service we provided to you was not a covered benefit, or if your maximum allowance has been used leading to non-payment by your insurance, you are personally responsible for balance owed.

Payments can be made in cash, checks, credit cards, or you can apply for Care Credit. If account is not paid within 60 days of the date of service, you will be responsible for interest charges (18% annum), collection agency fees, legal fees, and any other expenses incurred in collecting your account. There is a $25.00 fee for any check returned from your bank.

I authorize the insurance company to pay directly to this office any benefits from the insurance policy. It is agreed to have my signature considered to be "on File" in Boxes 36 and 37 of Standard ADA Insurance Form. I also authorize release of any information, relating to diagnosis and treatments, to insurance companies and health practitioners for the purposes of billing and referrals/consultations, respectively. I agree to pay for all services rendered by this office, and understand that I am responsible for any amounts not covered by my insurance; that I am ultimately responsible for all charges on my account.

I have read the above policies and terms, and agree to their content.

Signed_____Relationship to Patient _____ Date: _____

☐By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

Consent for Treatment

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care and further authorize and consent to the doctor choosing and employing such assistance as he/she deems fit. The doctors are obligated to inform patient or responsible person of all significant known risks, benefits, and alternative to any given treatment or therapeutic.

Signed_____Relationship to Patient _____ Date: _____

☐By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

-You may refuse to sign this acknowledgement-

The California State Board requires that patients are provided with updated Dental Material Fact Sheet only once prior to beginning of any restorative procedures. We will provide you with a hard copy, but to conserve paper resources, you can choose to view the link to this document on our website (http://www.dbc.ca.gov/formspubs/pub_dmfs_english_webview.pdf).

I acknowledge that I have received and read a copy of this office's Dental Materials Fact Sheet.

I am: The Patient _____ The Patient's Representative/Guardian _____

Signed _____ Date _____

☐By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

Print Name _____

Relationship to patient if patient's representative _____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement (Please specify)_____

_____ Other (Please specify)_____

Every individual has the right to adequate notice of; the uses and disclosures of protected health information that we make your right and our legal duties with respect to protect health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

-You may refuse to sign this acknowledgement-

I acknowledge that I have received and read a copy of this office's Notice of Privacy Practices.

I am: The Patient _____ The Patient's Representative/Guardian _____

Signed _____ Date _____

☐By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature.

Print Name _____

Relationship to patient if patient's representative _____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement.

(Please specify)_____

_____ Other (Please specify) _____

Every individual has the right to adequate notice of; the uses and disclosures of protected health information that we make your right and our legal duties with respect to protect health information.