Patient Information

Patient Name: ______________________________ Date: __________
Last, First MI (Preferred Name)

Address: ______________________________
Street Apartment #

____
City State Zip Code

Home Phone: __________ (Work): __________ Ext: ______ Cellular Phone: __________

Best phone number to reach you at: __________ email: __________

I agree to information by email: __________

Social Security #: __________ Drivers License #: __________ Birth Date: __________ Gender:

How did you hear about our office? ______________________________

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

Responsible Party if Different from Patient Information

Name: ______________________________ Relationship to patient: __________
Last, First MI (Preferred Name)

Address: ______________________________
Street Apartment #

____
City State Zip Code

Home Phone: __________ (Work): __________ Ext: ______ Cellular Phone: __________

Best phone number to reach you at: __________ email: __________

I agree to information by email: __________

Social Security #: __________ Drivers License #: __________ Birth Date: ____ Gender: __________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary Insurance Company: ______________________________ Group Plan Name: __________

Name of Insured: ______________________________
Last First MI

Insured's Birth Date: __________ Social Security # __________ ID # or Group #: __________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Secondary Insurance Company: ______________________________ Group Plan Name: __________

Name of Insured: ______________________________
Last First MI

Insured's Birth Date: __________ Social Security # __________ ID # or Group #: __________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Health Information for

Date of Last Dental Visit: ______________________ Reason for this visit: ____

Have you ever had any of the following? Please check yes or no:

Y N	Y N	Y N	Y N
☐☐ AIDS	☐☐ Excessive Bleeding	☐☐ Nervous Disorders	☐☐ Ulcers
☐☐ Allergies		☐☐ Pacemaker	☐☐ Venereal Disease
☐☐ Amoxicillin Allergy	☐☐ Fainting	☐☐ Penicillin Allergy	☐☐ Vicodin Allergy
☐☐ Anemia	☐☐ Glaucoma	☐☐ PreMed needed	
☐☐ Anesthetic Allergies	☐☐ Growths	☐☐ Pregnancy	OTHER:
☐☐ Arthritis	☐☐ Hay Fever	Due date:__________	____________________
☐☐ Artificial Joints	☐☐ Head Injuries	☐☐ Radiation Treatment	____________________
☐☐ Aspirin Allergy	☐☐ Heart Disease	☐☐ Respiratory Problems	____________________
☐☐ Asthma	☐☐ Heart Murmur	☐☐ Rheumatic Fever	____________________
☐☐ Blood Disease	☐☐ Hepatitis	☐☐ Rheumatism	____________________
☐☐ Cancer	☐☐ High Cholesterol	☐☐ Seizures	Medications:
☐☐ Cerebral Palsy	☐☐ High Blood Pressure	☐☐ Sinus Problems	________________________
☐☐ Chemotherapy/ Radiation therapy	☐☐ Hip Surgery	☐☐ Stomach Problems	________________________
	☐☐ Jaundice	☐☐ Stroke	________________________
☐☐ Codeine Allergy	☐☐ Kidney Disease	☐☐ Sulfa Allergy	________________________
☐☐ Diabetes	☐☐ Latex Allergy	☐☐ Tetracycline Allergy	________________________
☐☐ Dizziness	☐☐ Liver Disease	☐☐ Thyroid Problems	________________________
☐☐ Drug/Alcohol Problem	☐☐ Mental Disorders	☐☐ TMJ problems	________________________
☐☐ Emphysema	☐☐ Migraine Headaches	☐☐ Tremors	________________________
☐☐ Epilepsy	☐☐ Mitral Valve Prolapse	☐☐ Tuberculosis	________________________
☐☐ Erythromycin Allergy		☐☐ Tumors	________________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ 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: ____________________
- Have you ever taken prescription medications for weight loss (diet Pills)? ☐ Yes ☐ No
  If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
- Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

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 the doctors at the next appointment without fail.

____

Signature **date**

I have received a copy of the Dental Board of California's Dental Materials Fact Sheet:

____ Date: ______________________

Signature of patient, parent or guardian

I have received a copy of the HIPAA notice of Privacy Practices:

____ Date: ______________________

Signature of patient, parent or guardian

Agreement for Payment/Assignment and Release for Insurance

I hereby certify that the above personal and insurance information is correct. I understand that I am financially responsible for all charges incurred by me or my dependents and agree to pay for all charges not covered by my insurance company. 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.

I hereby assign my insurance benefits directly to Dr. XXXXXXXXXX and authorize the release of information necessary to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

I understand I will be charged for any appointments missed or cancelled without a 48 hour notification.

Patient Payments are collected on the day services are rendered. As a condition of your treatment by this office, financial arrangements must be made in advance. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

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 or my dental treatment.

I have read the above conditions of treatment and payment and agree to their content.

____________________________________ Date: ____________ Relationship to Patient: ____________________

Signature of patient, parent or guardian