HOW DID YOU HEAR ABOUT US? ☐ GOOGLE ☐ INSURANCE PROVIDER ____________

☐ BILLBOARD ☐ REDWOOD WEBSITE ☐ YELLOWPAGE ONLINE ☐ FRIEND ☐ RELATIVE ☐ OTHER ____________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? *Circle one:* MR MRS MS MISS DR **NAME:**

ADDRESS:	E-MAIL ADDRESS:
CITY, STATE:	BIRTH DATE: / / SEX: M F
ZIP CODE:	SOCIAL SECURITY NO.: - -
HOME PHONE:	**EMPLOYER:**
WORK PHONE:	EMERGENCY CONTACT:
CELL #:	NAME ____________
Method of Payment: Insurance ☐ Cash/Check ☐ Credit Card ☐	PHONE # ____________

DENTAL INSURANCE PRIMARY COVERAGE	DENTAL INSURANCE SECONDARY COVERAGE
EMPLOYEE NAME:	**EMPLOYEE NAME:**
ADDRESS:	ADDRESS:
CITY, STATE:	CITY, STATE:
ZIP CODE:	ZIP CODE:
HOME PHONE:	HOME PHONE:
WORK PHONE:	WORK PHONE:
BIRTH DATE: / / SEX: M F	BIRTH DATE: / / SEX: M F
SOCIAL SECURITY NO.: - -	SOCIAL SECURITY NO.: - -
EMPLOYER:	**EMPLOYER:**
INSURANCE NAME:	INSURANCE NAME:
INS. ADDRESS:	INS. ADDRESS:
GROUP # OR LOCAL #:	GROUP # OR LOCAL #:
SUBSCRIBER #:	SUBSCRIBER #:

MEDICAL INSURANCE PRIMARY COVERAGE	MEDICAL INSURANCE SECONDARY COVERAGE
INSURANCE NAME:	INSURANCE NAME:
INS. ADDRESS:	INS. ADDRESS:
GROUP #:	GROUP #:
SUBSCRIBER #:	SUBSCRIBER #:

The account holder is responsible for all account balances older than 90 days, regardless of insurance coverage or reimbursement status. All account balances 90 days and older will accrue a late payment charge of 2% monthly.
If account enters collection, a 21% collection fee will be added to the balance.

Your insurance policy is a contract between you and your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service. We accept cash, checks and most major credit cards.

Any missed appointments without 24 hours notice, except in an emergency, will result in a charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE ____________ DATE: __/__/__

PATIENT ACCOUNT REGISTRATION **NAME** ____________ **D/O/B** ____________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____________________________
(PRINT NAME PLEASE)

Signature: ____________________________ Date: ____________

Witness: ____________________________ Date: ____________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

For office use only:

Patient refused to sign. The following circumstances prohibited the patient from signing the acknowledgment:

____

Office Personnel (signature) **Office Personnel (print)**

Date: ____________

OFFICE POLICIES

INSURANCE

- Your insurance is a contract between you and your insurance company.
- You must be knowledgeable about your insurance benefits.
- If you do not inform us of insurance changes you are responsible for the payment of services rendered.
- If your insurance plan does not cover the services provided you are responsible for the payment of those services.
- All treatment plan presentations are estimates; any balance remaining after the insurance payment is your responsibility.

PAYMENT

- All deductibles and/or co-pays are due at the time services are rendered.
- If you do not have insurance, payment for services is due at the time service is rendered.

CANCELLATIONS/NO SHOWS

All cancellations/No shows within **24 hours** will be subject to a **$50 fee** for each appointment, that will be **required prior to rescheduling**. ____________
(Initial)

I HAVE READ AND UNDERSTAND THE ABOVE

____
PATIENT'S SIGNATURE

____
DATE

Preferred Pharmacy________________________ Pharmacy Phone Number________________________

1707 (7/11)

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: ________________ Date of Birth ________ Age:____ ☐ Male ☐ Female

Address ________________ Weight ________ Home Phone No. ________

________________ Height ________ Work Phone No. ________

________________ SSN # ________ Cell Phone No. ________

If you are completing this form for another person, what is your relationship to that person? Your Name ________________ Relationship ________

MEDICAL HISTORY

Physician's Name________________

Address ________________

Are you now under the care of a physician? YES ☐ NO ☐

If yes, for what reason? ________________

Are you presently taking any medications / drugs / pills? YES ☐ NO ☐

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

____

____

____

____

____

____

____

ALLERGIES / SENSITIVITIES:

Are you allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX

☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances ☐ **NONE**

Do you have, or have you ever had any of the following: (YES or NO)

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) heart valve	☐	☐	13 Anorexia	☐	☐	29 Drug Dependency	☐	☐	45 Autoimmune Disease	☐	☐
2 Previous infective endocarditis	☐	☐	14 Bulimia	☐	☐	30 Chemical Dependency	☐	☐	46 Artificial Joint / Prosthesis	☐	☐
3 Damaged valves in transplanted heart	☐	☐	15 Lung disease / COPD	☐	☐	31 Blood Disorders	☐	☐	47 Liver Disease	☐	☐
			16 Tuberculosis	☐	☐	32 Anemia	☐	☐	48 Hepatitis (circle one) Type A B C Other	☐	☐
4 Congenital heart disease (CHD)			17 Asthma	☐	☐	33 Leukemia	☐	☐			
Unrepaired, cyanotic CHD	☐	☐	18 Shortness of Breath	☐	☐	34 Prolonged Bleeding	☐	☐	49 Ulcers	☐	☐
Repaired (completely) in last 6 months	☐	☐	19 Respiratory Ailments	☐	☐	35 Hemophilia	☐	☐	50 Gastrointestinal Disease	☐	☐
Repaired CHD with residual defects	☐	☐	20 Emphysema	☐	☐	36 Sickle Cell Disease	☐	☐	51 GERD (gastric reflux)	☐	☐
5 Heart Disease/Surgery	☐	☐	21 Sinus Trouble	☐	☐	37 Cancer	☐	☐	52 Hard of Hearing	☐	☐
6 Heart murmur	☐	☐	22 Diabetes Type I or Type II	☐	☐	38 Tumors	☐	☐	53 Glaucoma	☐	☐
7 Heart pacemaker	☐	☐	23 Thyroid Problems	☐	☐	39 Chemotherapy	☐	☐	54 Cortisone Medication	☐	☐
8 Rheumatic fever/heart disease	☐	☐	24 Persistent swollen glands	☐	☐	40 Radiation Therapy	☐	☐	55 Fainting Spells	☐	☐
9 Mitral valve prolapse	☐	☐	25 Kidney Problems	☐	☐	41 Neurological Disorders	☐	☐	56 Organ Transplant	☐	☐
10 High/low blood pressure	☐	☐	26 Venereal Disease	☐	☐	42 Epilepsy	☐	☐	57 Removal of Spleen	☐	☐
11 Learning Disability	☐	☐	27 HIV Positive / AIDS / ARC	☐	☐	43 Stroke	☐	☐	58 Osteoporosis	☐	☐
12 Mental Health Disorder	☐	☐	28 Alcohol Addiction	☐	☐	44 Arthritis / Rheumatism	☐	☐	59 Sleep Disorder	☐	☐

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** or Paget's disease? ☐ YES ☐ NO

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ YES ☐ NO Date Treatment Began _____/_____/_____

DR COMMENTS	BLOOD PRESSURE
	/

Have you ever used or currently use tobacco products? ☐ YES ☐ NO How much? ____ How Often? ____

☐ cigarettes ☐ cigars ☐ pipe ☐ chew How long ago did you quit? ________

Do you drink alcoholic beverages? ☐ YES ☐ NO How much? ________ How often? ________

Have you had any other serious illness, hospitalization or accident? ☐ YES ☐ NO

If yes, please explain________________

WOMEN: Are you pregnant or suspect that you may be? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature________________________ Date ________

(PARENT/GUARDIAN)

Doctor Signature ________________________ Date ________

MEDICAL HEALTH HISTORY **NAME** ________________________ **#** ________

DENTAL HISTORY

What is the reason for your visit today? ____________________

Previous Dentist's Name ____________________ Address ____________________

Date of Last Visit ____________ Last Hygiene Visit ____________ Last X-Rays ____________

How often do you have dental examinations? ____________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other aids do you use? (Electric toothbrush, toothpick, etc.) ____________________

Do you have any dental problems? Yes☐ No☐

If yes, please describe ____________________

Are any of your teeth sensitive to:

	Yes	No
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or pressure?	☐	☐
Have you ever noticed any mouth odors or bad taste?	☐	☐
Do you frequently get cold sores, blisters or any lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to become caught between your teeth?	☐	☐

Do you:

	Yes	No
Clench or grind your teeth while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails, pipe)	☐	☐
Mouth breather while asleep or awake?	☐	☐
Snore?	☐	☐

Have you ever experienced:

	Yes	No
Clicking or popping of the jaw?	☐	☐
Pain? (Joint, ear, side of face)	☐	☐
Difficulty opening or closing the mouth?	☐	☐
Frequent headaches, neckaches, or shoulder aches?	☐	☐
Any pain or soreness in the muscles of your face or around the ears?	☐	☐

Have you ever had:

	Yes	No
Orthodontic treatment?	☐	☐
Oral surgery?	☐	☐
Teeth removed?	☐	☐
If so, have they been replaced?	☐	☐
Fixed Bridge?	☐	☐
Removable Partial?	☐	☐
Complete Denture?	☐	☐
Implants?	☐	☐
Are you happy with the replacement?	☐	☐
Periodontal Treatment?	☐	☐
Gum Surgery?	☐	☐
If so, when?		
By whom?		
Your teeth ground or the bite adjusted?	☐	☐
A serious injury to the mouth or head?	☐	☐

If so, please describe. Include cause. ____________________

	Yes	No
Do you like the appearance of your teeth; your smile?	☐	☐
Do you like the color of your teeth?	☐	☐
Are your teeth as straight as you would like?	☐	☐

What would you like to change most in the appearance of your teeth? ____________________

	Yes	No
Do you feel anxiety about having dental treatment?	☐	☐
Have you ever had an upsetting dental experience?	☐	☐

If yes, please describe, ____________________

How did you overcome your anxiety? ____________________

Is there anything else about having dental treatment that you would like us to know, please describe. ____________________

DR. COMMENTS:

I consent to the doctor's exam and necessary diagnostics for treatment including x-rays.

Patient Signature ____________________ Date ____________
(PARENT/GUARDIAN OF A MINOR)

Doctor Signature ____________________ Date ____________

DENTAL HISTORY **NAME** ____________________ **#** ____________