

Date

WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

SS/HIC/Patient ID #	Patie	nt Employer/s	School					
Patient Name	Empl	Employer/School Address						
Address								
City		lover/School	Phone					
State Zip								
E-mail				_ SS#				
Sex \square M \square F Age Birthday	Spou	se's Employe	er					
□ Married □ Widowed □ Single	☐ Minor Whor	n may we tha	ank for referring	you?				
□ Separated □ Divorced □ Partnered	d for years							
${\mathcal I}$	Dental Insu	ıraı	nce					
Subscriber's Name	In pa	In patient covered by secondary insurance? ☐ Yes ☐ No						
Relationship to Patient	Subs	Subscriber's Name						
Birthday SS#								
Insurance Co.				SS#				
Group # Phone								
Group # Friorie								
	Grou	0 #		Phone				
Home Phone Work	Best time a	Ext Cell Phone est time and place to reach you IN						
Name	•	,						
Home Phone Work								
Home Phone work	Prione	EXT	_ Cell Phone _					
Reason for today's visit	Dental Hi Please check (☑) "yes" or "no" Bad breath		if you have had		□ Yes	□ No		
	Bleeding gums	□ Yes □ N	No Lip or o	heck biting	□ Yes	□ No		
Former Dentist	Blisters on lips or mouth	☐ Yes ☐ N	No Loose t	teeth or broken fillings	☐ Yes	□ No		
City/State	Burning Sensation on tongue	□ Yes □ N			□ Yes			
	Chew on one side of mouth	☐ Yes ☐ N			☐ Yes			
Date of last dental visit	Cigarette, pipe or cigar smoking Clicking or popping jaw	☐ Yes ☐ N			☐ Yes			
Date of last dental X-ray	Dry mouth	☐ Yes ☐ N			☐ Yes			
	Fingernail biting	☐ Yes ☐ N			□ Yes			
How often do you floss?	Food collection between the teeth			•	□ Yes			
How often do you brush?	Foreign objects in mouth	□ Yes □ N		*	□ Yes	□ No		
	Grinding teeth	□ Yes □ N	No Sensitiv	vity when biting	□ Yes	□ No		
Do you wear contact lenses? ☐ Yes ☐ No	Gums swollen or tender	□ Yes □ N	No Sores o	or growths in mouth	☐ Yes	□ No		

Medical History

Physician's Name					Da	ate of last visit			
Phone			Pharmacy			Phone			
Please check (☑) "Yes" or "no'	' to indica	te if you							
AIDS	☐ Yes	□ No	High Blood Pressure	☐ Yes	□ No	Tonsillitis	☐ Yes	□ No	
Anemia	□ Yes		HIV Positive	☐ Yes	□ No	Tuberculosis	☐ Yes	□ No	
Arthritis, Rheumatism	☐ Yes	□ No	Jaundice	☐ Yes	□ No	Tumors or Growths	☐ Yes	□ No	
Asthma	☐ Yes	□ No	Jaw Pain	☐ Yes	□ No	Ulcer	☐ Yes	□ No	
Back Problem	☐ Yes	□ No	Kidney Disease	☐ Yes	□ No	Venereal Disease	☐ Yes	□ No	
Cancer	☐ Yes	□ No	Liver Disease	☐ Yes	□ No				
Chemical Dependency	☐ Yes	□ No	Low Blood Pressure	☐ Yes	□ No	Have you ever had or been	diagnosed	with:	
Chemotherapy	☐ Yes	□ No	Nervous Problems	☐ Yes	□ No	Artificial Heart Valves	☐ Yes		
Circulatory Problems	☐ Yes	□ No	Psychiatric Care	☐ Yes	□ No	Artifical Joints, Screws,			
Cortisone Treatments	☐ Yes	□ No	Radiation Treatment	☐ Yes	□ No	Pins, etc.	☐ Yes	□ No	
Cough, persistent or bloody	☐ Yes	□ No	Respiratory Disease	☐ Yes	□ No	Bleeding abnormally, with			
Diabetes	☐ Yes	□ No	Scarlet Fever	☐ Yes	□ No	extractions or surgery	☐ Yes	П №	
Emphysema	☐ Yes	□ No	Shortness of Breath	☐ Yes	□ No	Blood Disease	□ Yes		
Epilepsy	☐ Yes	□ No	Sinus Trouble	☐ Yes	□ No	Congenital Heart Lesions	□ Yes		
			Skin Rash	☐ Yes	□ No	Heart Murmur	□ Yes		
Fainting or dizziness	☐ Yes	□ No	Special Diet/Weight Loss	☐ Yes	□ No				
Glaucoma	☐ Yes	□ No	Stroke	☐ Yes	□ No	Hernia Repair	☐ Yes		
Headaches	☐ Yes	□ No	Swollen Feet or Ankles	☐ Yes		Mitral Valve Prolapse	☐ Yes		
Heart Problems	☐ Yes	□ No	Swollen Neck Glands	□ Yes		Pacemaker	☐ Yes		
Hepatitis Type	☐ Yes	□ No	Thyroid Problems	□ Yes		Rheumatic Fever	☐ Yes	□ No	
Herpes	☐ Yes	□ No	Thyrola i robiolilo	00	_ 140				
Have you ever had any complic	actions		Have you ever taken any of	these med	lications?	Are you allergic to:			
following dental treatment?		П№	Bisphosphonates	☐ Yes		Aspirin	☐ Yes	□ No	
			Blood Thinners	□ Yes		Barbiturates	☐ Yes	□ No	
If Yes, please describe			Coumadin	☐ Yes		Codeine	☐ Yes	□ No	
			Warfarin	□ Yes		Ibuprofen	☐ Yes	□ No	
			Diet Medications	☐ Yes		Latex	☐ Yes	□ No	
Have you ever been hospitalized			Dexfenfluramine	□ Yes		Local Anesthesia	☐ Yes	□ No	
any other health concerns?	⊔ Yes	⊔ No				Metals (i.e. gold)	☐ Yes	□ No	
If Yes, please describe			Fen-phen	☐ Yes		Penicillin	☐ Yes	□ No	
			Pondimin	☐ Yes					
NA/			Redux	☐ Yes		Other			
Women: Are you pregnant?	☐ Yes	□ NO	Levoxyl	☐ Yes					
Due date			Synthroid						
Are you nursing?	☐ Yes	□No	Please PRINT all medication	ns now tak	ing:				
Taking birth control pills?	☐ Yes	□ No							
			SIGNATURES						
To the best of my knowledge, the above	e informatior	is complet	te and correct. I understand that it is my	responsibility	to inform my	doctor if I, or my minor child, ever have	a change in	health.	
Insurance Assignment: I certify that I	, and/or my	dependent(s	s), have Insurance coverage with			a	and assign dir	ectly to	
				Nan		e Company(ies)	_	-	
Dr.			surance benefits, if any, otherwise paya		or services re	endered. I understand that I am financ	ially responsi	ble for	
all Charges whether or not paid by insu	irance. i autn	orize the us	se of my signature on all insurance subm	issions.					
The above-named doctor may use r	ny health ca	re informa	tion and may disclose such information	on to the abo	ove-named in	nsurance Company(ies) and their age	nts for the p	urpose	
of obtaining payment for services a	and determin		nce benefits or the benefits payable						
completed or one year from the date sign	gned below.								
Authorization to Release Protected I	Health Inforn	nation: Lun	derstand that there may be a need to co	nsult with othe	er health care	providers. I voluntarily authorize			
Authorization to Release Frederica	icaitii iiiiciii	iddioii. Tan	delocated that there may be a need to be	noun with our	or mountinounc	providere. I volumently dution20			
Dr		to use a	and/or disclose my Protected Health Info	rmation (PHI)	related to				
Name of Doctor Disclosing	PHI	Th	on information will be used and/or displace	ad for the nur	naca of	Describe in detail the Protected He	alth Information	1	
you are authorizing to be used and/	or disclosed	,. 11	ne information will be used and/or disclos	ed for the pur	pose oi	Describe in d each purpose for which you a	are authorizing		
you are durienzing to be deed and	0. 0.00.0000.					December in a cacin parpose for inner year	are dutirerizing		
	4! 4	d d/ d'-	. I authorize Dr.		(D t D	to receive and use the i	nformation.		
your Protected Health Info			closed. completed or one year from the date sig		e of Doctor Re understand th	•	av be redisclo	sed by	
			regulations, I understand that I may revoke						
			e any effect on any actions taken by the at			ing the PHI prior to their receipt of the rev	ocation. I unde	erstand	
that my treatment cannot be conditione	d on whether	I sign this	authorization. I understand I may refuse	to sign this au	thorization.				
Signature	of Patient, P	arent, Guai	rdian or Personal Representative			Date			
Please pri	nt name of P	atient Pare	ent, Guardian or Personal Representative	1		Relationship to Patient			
1 10000 pm	int ridino or r	auom, r aro	nt, Guardian of Forosital Reprosentative			reductioning to 1 date	JII.		
$\mathcal{D}o$	cto	r's	Commen	ts c	ına	lupdate			
Medical Clearance Letter Sent to						Date			

Date

Results ___



5286 Iron Horse Parkway Suite A Dublin, Ca 94568 (925) 587-1584

Office Policy Statement

Welcome to our office. We are pleased that you have selected our office. We find that communication with our patients regarding our office policy assists us in providing the best service to you and helps avoid misunderstandings. Please sign at the bottom that you recognize and agree to these terms. Please feel free to ask us any questions.

Dental Insurance

We are happy to help you file the necessary forms to insure that you receive the full benefits of your policy; HOWEVER we can make no guarantee of any estimate coverage. Your co-payment is due on the date of services rendered. Your insurance policy is an agreement between you, your employer and your insurance company. We ask that all patients be responsible for services rendered in this office. Services provided must be paid for at the time of treatment. There is an interest rate charged of $1\frac{1}{2}$ % per month to any account that is 45 days past due.

Appointments

We respect your appointment time and take every effort to begin your treatment as scheduled. We request at least 48 hours notice to allow another patient to use the time that had been set aside for your visit. Failure to let us know of your cancellation 48 hours in advance will result in a \$50.00 charge per hour to you.

Returned checks and Collection action

If a check is returned to us for insufficient funds, a \$25.00 service fee charge will be applied to your account. IF you are forwarded to our collection agency, you will be responsible for all charges, including interest, late charge fees, collection fees, and attorney's fee.

Thank you for taking the time to read this policy statement.
I (we) have read, understand, and agree to the above policy.
Responsible Party/Patient:
Date:



Privacy Practices Acknowledgement

I received the Notice of Privacy Practices and I have been provided an opportunity to review it. Name ______ Birth Date _____ Date _____