



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

| | |
|--|--|
| Date _____ | Occupation _____ |
| SS/HIC/Patient ID # _____ | Patient Employer/School _____ |
| Patient Name _____ | Employer/School Address _____ |
| Address _____ | _____ |
| City _____ | Employer/School Phone _____ |
| State _____ Zip _____ | Spouse's Name _____ |
| E-mail _____ | Birthday _____ SS# _____ |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthday _____ | Spouse's Employer _____ |
| <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor | Whom may we thank for referring you? _____ |
| <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years | |

Dental Insurance

| | |
|-------------------------------|---|
| Subscriber's Name _____ | In patient covered by secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Relationship to Patient _____ | Subscriber's Name _____ |
| Birthday _____ SS# _____ | Relationship to Patient _____ |
| Insurance Co. _____ | Birthday _____ SS# _____ |
| Group # _____ Phone _____ | Insurance Co. _____ |
| | Group # _____ Phone _____ |

Phone Numbers

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Spouse's Work _____ Best time and place to reach you _____ IN

CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Ext _____ Cell Phone _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-ray _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

| | |
|--|---|
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Foreign objects in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medical History

Physician's Name _____ Date of last visit _____

Phone _____ Pharmacy _____ Phone _____

Please check (X) "Yes" or "no" to indicate if you have had any of the following:

| | | |
|-----------------------------|------------------------------|-----------------------------|
| AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | |
| Fainting or dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If Yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

If Yes, please describe _____

Women: Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

| | | |
|--------------------------|------------------------------|-----------------------------|
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV Positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaw Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Special Diet/Weight Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swollen Feet or Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever taken any of these medications?

| | | |
|------------------|------------------------------|-----------------------------|
| Bisphosphonates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Thinners | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coumadin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Warfarin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diet Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dexfenfluramine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fen-phen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pondimin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Redux | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Levoxyl | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Synthroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please PRINT all medications now taking: _____

Phone _____

| | | |
|-------------------|------------------------------|-----------------------------|
| Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tumors or Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had or been diagnosed with:

| | | |
|--|------------------------------|-----------------------------|
| Artificial Heart Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints, Screws, Pins, etc. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia Repair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you allergic to:

| | | |
|--------------------|------------------------------|-----------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Barbiturates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Codeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ibuprofen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Local Anesthesia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Metals (i.e. gold) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other _____

SIGNATURES

To the best of my knowledge, the above information is complete 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), have Insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all Charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____
Name of Doctor Disclosing PHI Describe in detail the Protected Health Information
_____. The information will be used and/or disclosed for the purpose of _____
you are authorizing to be used and/or disclosed. Describe in detail each purpose for which you are authorizing

_____, I authorize Dr. _____ to receive and use the information.
your Protected Health Information to used and/or disclosed. Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no longer be protected by federal privacy regulations, I understand that I may revoke this authorization at any time by notifying. In writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Doctor's Comments and update

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____



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 1½ % 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: _____



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Privacy Practices Acknowledgement

Acknowledgement Form

I received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Birth Date _____

Signature _____

Date _____