ANSON
DENTAL STUDIO

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 _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthday _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber's Name _____

Relationship to Patient _____

Birthday _____ SS# _____

Insurance Co. _____

Group # _____ Phone _____

In patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthday _____ SS# _____

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

Medical History

Physician's Name _____ Date of last visit _____

Phone _____ Pharmacy _____ Phone _____

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

AIDS	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problem	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type _____	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet/Weight Loss	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ 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

Have you ever taken any of these medications?

Bisphosphonates	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Please PRINT all medications now taking: _____

_____

Have you ever had or been diagnosed with:

Artificial Heart Valves	☐ Yes	☐ No
Artifical Joints, Screws, Pins, etc.	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

Are you allergic to:

Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ 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 d 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 _____

ANSON
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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 _____