# Dublin Dental Care

6851 Amador Plaza Rd. #104B, Dublin, CA 94568

Please fill in this form COMPLETELY as this information is ESSENTIAL for correct insurance billing to ensure that you receive all the benefits due to you.

## *CONFIDENTIAL PATIENT INFORMATION*

| | | | | |
|---|---|---|---|---|
| Name | | Birth date | Age | Male Female |
| SSN | Driver's License | | Married Single Divorced Separated Widowed | |
| Address | | City | State | Zip |
| Home☎ | Business☎ | Mobile | e-mail | |
| Employer | | | Occupation | |
| Business Address | | | | |
| Spouse's Name | | | Spouse's SSN | |
| Spouse's Employer | | | Address | |
| Physician | ☎ | | Address | |
| Former Dentist | ☎ | | Address | |
| Why are you changing dentists? | | | | |
| Purpose of today's visit? | | | | |
| Whom may we thank for referring you to our practice? | | | | |

## *INSURANCE INFORMATION*

| | | |
|---|---|---|
| Person financially responsible for this account? | | Relationship |
| Primary Insurance Company | Plan# | Group |
| Insured's Name | | Relationship |
| Insured's Birthday | | Insured's SSN |
| Secondary Insurance Company | Plan# | Group |
| Insured's Birthday | | Insured's SSN |

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. And the financial responsibility of each patient must be determined before treatment. All emergency dental services, or any dental performed without prior financial arrangements must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
I agree to pay for all services rendered. In the event that payment is not made within thirty(30) days of receipt of statement, a service charge at legal rate may be added to the past due balance. If a collection agency services are required, I future agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to and become part of the principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of Social Security number or any other information I Have given you. I understand that any and all fees incurred for dental treatment are my total responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefits, I will be financially responsible to pay up to the agreed upon fee schedule

We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee.

***Signature: X*** _____ ***Date:*** _____

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***HEALTH QUESTIONNAIRE*** ***Patient's Name:*** _____

Answering these questions completely is for your benefit and assures your safety during treatment.

| | | |
|---|---|---|
| 1. Are you now under the care of a physician? Condition treated: | YES | NO |
| 2. Have you ever had a serious illness, operation or hospitalization? | YES | NO |
| 3. Are you taking medications? If yes, what? | YES | NO |
| 4. Have you ever used recreational drugs (eg. Marijuana, cocaine etc…)? | YES | NO |
| 5. Have you ever been pre-medicated with antibiotics for dental treatment? If yes, what? | YES | NO |
| 6. Do you use tobacco in any form? If yes, what and how much? | YES | NO |
| 7. Have you ever taken the drugs "Phen-Phen" or "Redux"? | YES | NO |
| 8. Have you ever taken or are taking Bisphosphonate (Fosamax)? | YES | NO |
| 9. (Women) Are you pregnant? If so, when is the due date? | YES | NO |
| 10. (Women) Are you taking birth control pills? | YES | NO |

11. Do you have or have you ever had any of the following?

Cardiovascular System

| | | |
|---|---|---|
| Rheumatic Fever* | YES | NO |
| Heart Murmur* | YES | NO |
| Heart Attack | YES | NO |
| Shortness of breath / Ankle Swelling | YES | NO |
| Angina Pectoris | YES | NO |
| High Blood Pressure | YES | NO |
| Congenital Heart Disease | YES | NO |
| Mitral Valve Prolapse* | YES | NO |
| Artificial Heart Valve* | YES | NO |
| Pace Maker | YES | NO |
| Heart Surgery | YES | NO |
| Congestive Heart Failure | YES | NO |

***Bone / Muscles***

| | | |
|---|---|---|
| Arthritis/ Rheumatism | YES | NO |
| Artificial Joints/Limbs* | YES | NO |

***Digestive System***

| | | |
|---|---|---|
| Hepatitis A/B/C<br>**Please Circle which kind** | YES | NO |
| Ulcers | YES | NO |

***Endocrine***

| | | |
|---|---|---|
| Diabetes | YES | NO |
| Thyroid Disease(Hyper)/ (Hypo) | YES | NO |

***Allergies to Medications***

| | | |
|---|---|---|
| Penicillin, Amoxicillin | YES | NO |
| Tetracycline | YES | NO |
| Erythromycin | YES | NO |
| Clindamycin | YES | NO |
| Sulfa Drugs | YES | NO |
| Codeine | YES | NO |
| Aspirin | YES | NO |
| Epinephrine Sensitivity | YES | NO |
| Other | YES | NO |

Urinary

| | | |
|---|---|---|
| Kidney Disease | YES | NO |
| Burning on Urination | YES | NO |
| Sexually Transmitted Infection | YES | NO |

***Blood***

| | | |
|---|---|---|
| Bruise Easily | YES | NO |
| Anemia | YES | NO |
| Blood Transfusion | YES | NO |
| AIDS / HIV* | YES | NO |
| Stroke | YES | NO |

***Respiratory***

| | | |
|---|---|---|
| Bronchitis | YES | NO |
| Asthma | YES | NO |
| Emphysema | YES | NO |
| Tuberculosis (TB) | YES | NO |

***Nervous System***

| | | |
|---|---|---|
| Epilepsy/ Seizures/ Convulsions | YES | NO |
| Dizziness | YES | NO |
| Fainting | YES | NO |
| Stroke | YES | NO |
| Psychiatric Treatment | YES | NO |

***Others***

| | | |
|---|---|---|
| Glaucoma | YES | NO |
| Hay Fever | YES | NO |
| Ringing in the Ears | YES | NO |
| Allergy to Latex | YES | NO |
| Radiation Therapy/ Chemotherapy | YES | NO |
| Cerebral Palsy | YES | NO |
| Metal Allergies | YES | NO |
| Tumors or Growths | YES | NO |
| Sinus Problems | YES | NO |
| Allergies / Hives | YES | NO |
| Other | YES | NO |

| | | |
|---|---|---|
| 11. Do you have any other medical issues not mentioned above? | YES | NO |

Patient/Guardian's Signature _____ Date: _____

Reviewing Doctor _____ Date: _____

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***DENTAL HISTORY*** ***Patient's Name:*** _____

| | | | | |
|---|---|---|---|---|
| 1. Do you have any discomfort, pain or concerns at this time? Describe: | | | YES | NO |
| 2. Have you ever had serious trouble with previous dental treatment? Describe: | | | YES | NO |
| 3. Does dental treatment make you nervous? | NO | SLIGHTLY | MODERATELY | EXTREMELY |
| 4. Have you ever been treated for Gum Disease or Periodontal Disease or Pyorrhea? If so, when? | | | YES | No |
| 5. When were your last x-rays taken? | | | | |
| 6. When was your last dental visit? | | | | |
| 7. When was your last cleaning? | | | | |
| 8. Have you ever had trouble with local Anesthetic? What Happened? | | | YES | NO |

9. Do you currently have, or ever had, any of the following?

Mouth

| | | |
|---|---|---|
| Bleeding, Sore Gums | YES | NO |
| Unpleasant taste / Bad Breath | YES | NO |
| Frequent blisters | YES | NO |
| Swelling lumps in mouth | YES | NO |
| Biting cheeks/ lips | YES | NO |
| Orthodontic treatment ie braces | YES | NO |
| Clicking/ popping noises from jaw | YES | NO |
| Difficulty opening/ closing jaw | YES | NO |
| Diagnosed with TMJ problem | YES | NO |

Teeth

| | | |
|---|---|---|
| Loose teeth | YES | NO |
| Sensitive to hot | YES | NO |
| Sensitive to cold | YES | NO |
| Sensitive to sweets | YES | NO |
| Sensitive to biting | YES | NO |
| Food impaction | YES | NO |
| Clenching/ Grinding | YES | NO |
| Shift/ Change in bite | YES | NO |
| | | |

Prosthetics

| | | | | | | |
|---|---|---|---|---|---|---|
| Full Upper denture | YES | NO | How old? | Is it comfortable? | YES | NO |
| Full lower denture | YES | NO | How old? | Is it comfortable? | YES | NO |
| Partial upper denture | YES | NO | How old? | Is it comfortable? | YES | NO |
| Partial lower denture | YES | NO | How old? | Is it comfortable? | YES | NO |

| | | | | |
|---|---|---|---|---|
| 10. How often do you brush? | NEVER | ONCE DAILY | TWICE DAILY | AFTER EVERY MEAL |
| 11. How often do you floss: | NEVER | INFREQUENTLY | DAILY | AFTER EVERY MEAL |
| 12. Do you like the color of your teeth | | | YES | NO |
| 13. Would you be interested in bleaching your teeth? | | | YES | NO |

Patient/Guardian's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I, _____ have received a copy of this office's Notice of Privacy Practices.**

_____

**{Please Print Name}**

_____

**{Signature}**

_____

**{Date}**

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**For Office Use Only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining the acknowledgement
- Other ( Please Specify)

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_____

_____