PATIENT INFORMATION

Name_____ Birth date_____ Social Security_____

Address _____ City_____ State_____ Zip_____

Please Circle One: Married Separated Widowed Sex: Male Female
Divorced Single Minor

E-mail_____ Employer_____

Home Phone (____) _____ Cell Phone (____) _____

Spouse or Parent's Name_____ Employer_____ Phone (__) _____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone (__) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relation to Patient _____

Address_____ Home Phone (____) _____

Employer_____ Cell Phone (_____) _____

INSURANCE INFORMATION

Name of Insured_____ Relation to Patient _____

Birthday _____ Social Security #_____ Date Employed_____

Employer_____ Work Phone (____) _____

Employer Address_____ City_____ State _____ Zip_____

Insurance Company_____ Group # _____

Address_____ City_____ State _____ Zip_____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Please (X) if you have had problems with any of the following:

- o Bad breath
- o Bleeding gums
- o Clicking or popping jaw
- o Food collection between the teeth
- o Grinding teeth
- o Loosing teeth or broken fillings
- o Periodontal treatment
- o Sensitivity to cold, hot, or sweets
- o Sores or growths in your mouth

How often do you floss? _____

How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? Y N If yes, describe _____

Have you taken alendronate (Fosamax), risedronate (Actonel), received intravenous bisphosphonates (Aredia or Zometa)? Y N

(Women) Are you pregnant? Y N Nursing Y N Taking birth control pills Y N

Please answer yes or no to the following:

Cardiovascular Disease	Y N	Mitral valve prolapse	Y N	Arthritis	Y N	Hepatitis, Jaundice	Y N
Angina	Y N	Pacemaker	Y N	Asthma	Y N	Epilepsy	Y N
Arteriosclerosis	Y N	Rheumatic fever	Y N	Bronchitis	Y N	Fainting spells	Y N
Congestive heart failure	Y N	Abnormal Bleeding	Y N	Emphysema	Y N	Sleep Disorder	Y N
Damaged heart valves	Y N	Anemia	Y N	Sinus Trouble	Y N	Mental health	Y N
Heart attack	Y N	Blood transfusion	Y N	Tuberculosis	Y N	Recurrent Infection	Y N
Heart murmur	Y N	Hemophilia	Y N	Cancer/Chemotherapy	Y N	Kidney problems	Y N
Low blood pressure	Y N	AIDS/HIV	Y N	Radiation Therapy	Y N	Night sweats	Y N
High blood pressure	Y N	Autoimmune disease	Y N	Chest pain	Y N	Osteoporosis	Y N
Other congenital heart defects	Y N		Y N	Chronic pain	Y N	Swollen glands	Y N
				Diabetes Type I/II	Y N	Headaches	Y N
				Eating disorder	Y N	Severe weight loss	Y N
				Ulcers	Y N	Excessive urination	Y N
				Thyroid problems	Y N	Sexually Transmitted	Y N
				Stroke	Y N	Disease	Y N
				Glaucoma	Y N		

List medications you are currently taking: _____

_____

_____

_____

List Allergies: _____

_____

_____

_____

Patient Signature _____ **Date** _____

Dental Questionnaire

If you could *change* anything about your smile which of the following would you want? (Check all that apply)

☐ **Whiter**	☐ **Close space or spaces**	☐ **Replace chipped teeth**
☐ **Replace missing teeth**	☐ **Replace old crowns**	☐ **Remove silver fillings**
☐ **Less gum showing**	☐ **Remove stains/spots on teeth**	☐ **Straighter**
☐ **Replace old plastic filling(s)**	☐ **Excess showing of teeth**	☐ **Reshape/resize my teeth**

In presenting your treatment plan and talking to the doctor please let us know which is best for you?

☐ **I like lots of information and details** ☐ **I like just the basics and facts**

HIPAA PRIVACY

Acknowledgement of Receipt of Privacy Practices

Purpose: The purpose of this form us used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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

_____	_____	_____
Signature of Patient or Guardian	**Relationship to Patient**	**Date**

For Office Use Only

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

- **□ Individual refused to sign**
- **□ Communication barriers (such as language barrier) prohibited obtaining the acknowledgement**
- **□ An emergency situation prevented us from obtaining acknowledgement at the time of service**
- **□ Other (Please specify) _____**

OUR FINANCIAL POLICY

It is important to us that the quality of our business services matches the quality of dental care. We want the handling of your account, from the start, to be perceived as an extension of the dental care we provide to you and your family. As with any partnership, both parties have a role to play. Our role is to provide you with quality treatment and service. In turn, your role is to pay for your treatment at the time of service. Our team will work with you to determine what financial arrangements work best for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

Cancellation fee: Del Mar Highlands Dentistry reserves the right to charge for any no show appointments or appointments not cancelled within 48 hours and are subject to a fee of $50.00 per hour of appointment time scheduled.

AUTHORIZATION AND RELEASE

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.

We file insurance claims for all patients with insurance benefits however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance without complete insurance information. Your insurance is a contract between you and your insurance company and we are not a party to the contract. If your insurance has not paid on your claim within 45 DAYS, the full balance will automatically be transferred to you. That balance will be due upon billing.

BY SIGNING BELOW YOU AGREE THAT YOU READ, UNDERSTAND, AND ACCEPT OUR FINANCIAL, CANCELATION, AND INSURANCE PHILOSOPHY AND POLICIES

Patient Signature: _____ Date: _____