

PATIENT INFORMATION FORM

APPT DATE _____@_____

Date _____ Patient Name _____ Nickname _____
 Male Female Married Single Child Other

Date of Birth _____ SS# _____ Driver's License # _____

Address _____ Apt# _____ City & Zip _____

Phone # _____ Cell Home Another Phone # _____ Cell Home

Patient Employed by _____ Occupation _____

Email _____ Printer YES NO

How did you learn about our office? Phone Book Insurance web site 1800DENTIST Internet Search Drive By Other

If a person referred you please give us that person's name _____

RESPONSIBLE PARTY IF A DEPENDENT CHILD OR check here if same as above

Is patient a minor? Yes No Full-time Student? Yes No Name of School _____

Name of Responsible Party: _____

Address _____ Apt# _____ City & Zip _____

Phone # _____ Cell Home Another Phone # _____ Cell Home

Relationship to Patient Parent Spouse Other

If patient is a minor, primary residency Both Parents Mom Dad Step Parent Shared Custody Guardian

DENTAL BENEFIT PLAN INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Date of Birth _____

Employer _____ Occupation _____

Primary Dental Insurance Company _____ Phone _____

Insurance ID or SS # _____ Group or Plan Number _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Date of Birth _____

Employer _____ Occupation _____

Secondary Dental Insurance Company _____ Phone _____

Insurance ID or SS # _____ Group or Plan Number _____

Office use only

ELIGIBILITY CHECKED

EMAIL SENT

CONFIDENTIAL MEDICAL AND DENTAL HEALTH HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

1. Reason for this visit _____
2. When was your last dental visit? _____
3. Name and phone number of previous dentist _____

I. PLEASE CIRCLE YES TO THOSE THAT APPLY

My gums bleed when I brush	yes	I clinch or grind my teeth	yes
My teeth are sensitive to sweets	yes	I have had orthodontic treatment	yes
My teeth are sensitive to hot & cold	yes	I bite my lips or cheeks frequently	yes
I feel pain in my tooth/teeth	yes	I wear a partial denture or full denture	yes
I have sores or lumps in my mouth	yes	I have had difficulty with extractions	yes
I have clicking in my jaw joint	yes	I have had prolonged bleeding from extractions	yes
I have difficulty opening or closing	yes	I have had a deep cleaning	yes
I feel soreness in my jaw joint	yes	I have a broken tooth/filling	yes
I have difficulty in chewing	yes	I have bad breath	yes

II. IS THERE ANYTHING YOU WOULD LIKE TO CHANGE OR DISCUSS ABOUT YOUR SMILE?

Teeth Whitening	yes	Orthodontic treatment (braces)	yes
Implants for missing teeth	yes	Cosmetic restorations/veneers	yes
Replace Silver fillings with white	yes	Sedation Dentistry	yes

Other – Please explain _____

III. Circle appropriate answer

1. Yes / No Is your general health good?
If NO, explain _____
2. Yes / No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes / No Are you being treated by a physician now?
If YES, explain _____
5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____
6. Yes / No Are you in pain now?
If YES, explain _____
7. Yes / No Have you ever been pre-medicated for dental treatment?
If YES, why _____
8. Yes / No Do you snore? Yes/No Do you wear a CPAP? Yes/No Have you had a sleep study? Yes/No
If YES, when _____
9. Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

IV. Have you taken any of the following in the last three months? (circle yes or no for each)

Yes / No Antibiotics	Yes / No Recreational drugs	Yes / No Alcohol
Yes / No Aspirin	Yes / No Over the counter medications	Yes / No Supplements
Yes / No Anti-depressants	Yes / No Corticoid - Steroids	Yes / No Weight loss medication
Yes / No Fossamax/Boniva	Yes / No Tobacco in any form	

Please list the prescriptions medications that you take _____

V. Are you allergic to or have you had a reaction to any of the following (circle yes or no for each)

Yes / No Aspirin	Yes / No Food	Yes / No Percodan
Yes / No Codeine	Yes / No Erythromycin	Yes / No Tetracycline
Yes / No Darvon	Yes / No Demerol	Yes / No Valium
Yes / No Local Anesthetic (Novacain or Xylocaine)	Yes / No Latex	Yes / No Vicodin
	Yes / No Penicillin/amoxicillin	Yes / No Metal/nickel

Other allergies _____

VI. Have you experience any of the following? (circle yes or no for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficultly urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problem

VII. Have you had or do you have any of the following? (circle a yes or no for each)

Yes / No Acid reflux	Yes / No Eye disease	Yes / No Kidney/bladder disease
Yes / No Anemia	Yes / No Hardening of arteries	Yes / No Liver disease
Yes / No Artificial joint	Yes / No Heart attack	Yes / No MS
Yes / No Asthma	Yes / No Heart defects	Yes / No Night sweats
Yes / No Auto immune disease	Yes / No Heart disease	Yes / No Osteoporosis
Yes / No Blood pressure – high	Yes / No Family history of heart disease	Yes / No Radiation therapy
Yes / No Cancer / tumors	Yes / No Heart murmurs	Yes / No Rheumatic fever
Yes / No Canker or cold sores	Yes / No Heart MVP	Yes / No Sexually transmitted disease
Yes / No Chemotherapy	Yes / No Heart pacemaker	Yes / No Skin disease
Yes / No Cosmetic surgery	Yes / No Heart surgery	Yes / No Stroke
Yes / No Dental anxiety	Yes / No Hepatitis A B C	Yes / No Surgeries
Yes / No Diabetes	Yes / No Herpes	Yes / No Thyroid disease
Yes / No Family history of diabetes	Yes / No HIV/AIDS	Yes / No Tonsillitis
Yes / No Eating disorders	Yes / No Hives/skin rash	Yes / No Transplants
Yes / No Emphysema	Yes / No Hospitalization	Yes / No Tuberculosis
Yes / No Epilepsy/Seizures	Yes / No Hypoglycemia	Yes / No Ulcers/stomach disease

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If, YES, explain _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications. Furthermore, I will not hold my dentist or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

X _____ Date _____

Patient (or parent or guardian of minor child)

Dentist Signature _____ Date _____

VIII. Women only

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**PRACTICE POLICIES CONSENT FOR SERVICES
AND ACKNOWLEDGEMENT OF OFFICE POLICIES, PRIVACY PRACTICES AND DENTAL
MATERIALS FACT SHEET**

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with my treatment or my child's treatment.
4. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance, as deemed fit, to provide recommended treatment.
5. PROSTHETICS: Crowns, Dentures, Bridges, etc, Failure by member to return for the delivery of these items is subject to doctor time and lab fee charges. **MUST INITIAL HERE _____**
6. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient. The costs incurred for their care and financial responsibility on the part of each patient must be determined before treatment.
7. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. A service charge of 1 ½% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 90 days. All patient with a balance on the account will receive a billing statement, regardless of insurance.
8. I understand that where appropriate, credit bureau reports may be obtained.
9. Collection fees: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred. **MUST INITIAL HERE _____**
10. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Furthermore, I hereby authorize payment directly to Vimala Vontela, DDS of the group insurance benefits otherwise payable to me.
11. I authorize the use of my social security number to file my dental claims in the event I cannot provide an insurance identification number. I also acknowledge I need to provide the office a copy of my California state driver's license.
12. I understand it is my responsibility to advise your office of any changes in the information contained on this form. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my dental care.
13. I understand the office requests a 48 hour notification in the event an appointment must be rescheduled and requires a 24 hours notice or a charge may be incurred. **MUST INITIAL HERE _____**
14. I acknowledge I have received or have access to the office's Notice of Privacy Practice and a copy of the Dental Material Fact Sheet.
15. I have read the above conditions and agree to the content.
16. **May we leave messages on your phone regarding your dental care and appointment times?**
Home phone YES NO CELL PHONE YES NO

X

Signature of guarantor of payments and/or patient, parent or guardian Date Relationship to patient