...Just Smile

GALE RANCH DENTAL GROUP

NEWPARK MALL DENTAL GROUP

Waterford DENTAL GROUP

Premier Family Dentistry
Proudly Serving the Bay Area for over 28 years

ABOUT YOU

Today's Date: _____
Email Address: _____
Name: _____
I prefer to be called: _____ _____
Birth date: _____/_____/_____ Age: _____
SS#: _____
Home address: _____
City: _____ St. _____ Zip _____
Home Phone#: _____
Cell/Other#: _____
Work Phone#: (_____) _____ Ext: _____
Driver's License#: _____

Marital Status:

❑ Single ❑ Married ❑ Partnered
❑ Divorce/Separated ❑ Widowed

Employer: _____
Occupation: _____
When and where are best times to reach you? _____
_____
Whom May we thank for referring you? _____
Others Family members seen by us? _____
Optional Info to help the doctor get to know you:
Your Special Interest/Hobbies: _____
How long have you lived in area? _____

SPOUSE INFORMATION

His/Her Name: _____
Employer: _____
Work Phone#: (_____) _____ Ext: _____
SS#: _____
Birth date: _____/_____/_____ Age: _____
Driver's License#: _____

PRIMARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#: (_____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/___/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

SECONDARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#: (_____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/___/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

Authorization and Release:
I understand that I am Responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of patient:

_____

Date:

_____

MEDICAL HISTORY

Do You Have a personal Physician? ❑ Yes ❑ No
Physician's Name:_____
Phone#:(_____)_____
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you had any metals rod, pins, or implants? ❑ Yes ❑ No
Are you taking any prescriptions/over the counter drugs? ❑ Yes ❑ No
Please List each One: _____
_____
_____

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No
Have you ever taken Phen-fen? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No

For Women Only

Are you using a prescribed method of birth control? ❑ Yes ❑ No
Are You Pregnant? Week#____ ❑ Yes ❑ No
Are You Nursing? ❑ Yes ❑ No
Are you taking any birth control? ❑ Yes ❑ No

Have you ever had any of the followings diseases or medical problems?

Abnormal Bleeding	❑ Yes ❑ No	Herpes /Fever Blisters	❑ Yes ❑ No
AIDS	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Alcohol/Drug abuse	❑ Yes ❑ No	HIV	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Hospitalized for any reason	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No
Artificial Bones/Joints/Valves	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Lupus	❑ Yes ❑ No
Cancer/Chemotherapy	❑ Yes ❑ No	Mitral Valve Prolapsed	❑ Yes ❑ No
Colitis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Congenital Heart Defect	❑ Yes ❑ No	Psychiatric Problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Difficulty Breathing	❑ Yes ❑ No	Rheumatic/Scarlet fever	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Fainting Spells	❑ Yes ❑ No	Sickle Cells Disease/Traits	❑ Yes ❑ No
Frequent Headache	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Hay Fever	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Heart Attack/Surgery	❑ Yes ❑ No	Tuberculosis (TB)	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Hemophilia	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No		

Please List any serious medical condition(s) that you ever had:

_____
_____
_____

Medications:

List Medications (Prescribed/etc) you are currently taking:

_____
_____
_____

Are you allergic to any of the following:

Aspirin	❑ Yes ❑ No	Jewelry Metals	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No
Dental Anesthetics	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Other	❑ Yes ❑ No

Please list any drugs /materials that you are allergic to:

_____
_____
_____

DENTAL HISTORY

Reason For Today's Visit:_____
_____
Former Dentist:_____
Address:_____
Date Of Last Dental Visit:_____
Date Of Last Dental X-rays:_____
Your Current dental health is ❑ Good ❑ Fair ❑ Poor
Are You currently In Pain? ❑ Yes ❑ No
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No
Have you ever had Periodontal Disease? ❑ Yes ❑ No
Do You now or have ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ? ❑ Yes ❑ No
Are your teeth sensitive to sweets,heat,cold or anything else? ❑ Yes ❑ No
Are your teeth sensitive when biting? ❑ Yes ❑ No
Do you have sores of growth in your mouth? ❑ Yes ❑ No
Do you have any loose teeth? ❑ Yes ❑ No
Do you still have wisdom teeth? ❑ Yes ❑ No
Would You Like Fresher Breath? ❑ Yes ❑ No
Whiter Teeth? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No

If not,what would you change?_____
_____
_____
_____

Authorization and Release:

I have read the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor:

_____

Date:

_____

OFFICE USE ONLY

I verbally reviewed the Medical / Dental Infomation with the patient named herein.

Initials:_____Date:_____

Doctor's Commets:_____
_____
_____
_____
_____
_____

Office Policies

New Patient Paperwork

Please complete the new patient paperwork prior to arriving to your appointment. When you do not do this, it delays your appointment and other patients after you.

Missed Appointments

Our goal is to provide quality to all of our patients. When an appointment is scheduled, a block of time in the doctors' schedule has been allotted for you and your family.

We reserve the right to charge an initial $50.00 fee for any missed appointment that has not been canceled 24 hours prior to the scheduled appointment time.

Due to the high demand of our Saturday appointments, 48 hour notice is required prior to the scheduled appointment time if unable to keep this appointment.

Late Appointments

All patients that arrive more than 15 minutes late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, parent, or legal guardian, agree to bear full financial responsibility for all services provided if:

1. You are determined not to be eligible for insurance coverage.
2. The services are not a covered benefit under your plan.
3. There is a patient portion determined by your insurance plan.

Please keep in mind that any estimates presented to you for dental treatment is only an ESTIMATE of what your insurance company will pay. Financing options are available.

Returned checks

A fee of $35.00 for returned checks returned to us for any reason. Future services will require payment by cash or credit card.

Signature _____ Date _____