SAN RAMON
DENTAL EXCELLENCE

Patient Information

Date:

Name.....
Last First MI (preferred name)

Address: .....

City/Stat/Zip:.....

Home Telephone: ..... Cell:.....

Email Address: .....

DOB: .....Occupation:.....

Dental Information

Approx. date of last Dental Visit.....Former Dentist Name.....

Reason for Today's Visit.....

Your Dental Issues today: Please circle all that apply

Bleeding gums
Sensitive Teeth
Grinding / Clenching teeth
Jaw joint pain or clicking
Anxiety with dental treatment
Previous complications with dental treatment
Currently taking pain medication for a tooth /gum
Bad odor or taste in mouth
Any ulcers or lumps / bumps
Dry Mouth

Please circle the following to discuss with our team:

Straighter smile
Whiter smile
Complete Smile Makeover
Chipped or worn fillings / crowns
Replace missing teeth
Recontouring of uneven gums
Replacement of old silver fillings

Are you sleeping well:

Do you snore loudly: Yes No
Do you feel tired/fatigue during the day: Yes No
Has anyone observed you stop breathing during sleep: Yes No
Do you have problems keeping your legs still at night: Yes No
Suffer from morning headaches: Yes No
Have you suffered from High Blood Pressure or gastric acid reflux: Yes No
Do you currently wear a CPAP or other sleep device: Yes No , if YES are you happy with it: Yes No

MEDICAL INFORMATION

Do you now or have you ever had any of the following?

Yes	No	AIDS or HIV	Yes	No	Cancer/Tumors	Yes	No	Head Injuries
Yes	No	Allergies or Hives	Yes	No	Chemotherapy	Yes	No	Heart Disease
Yes	No	Anemia	Yes	No	Cold Sores/Herpes	Yes	No	Heart Murmur
Yes	No	Arthritis	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A, B, or C
Yes	No	Artificial Joints	Yes	No	Diabetes	Yes	No	High Blood Pressure
Yes	No	Artificial Heart Valve	Yes	No	Dizziness	Yes	No	Jaundice
Yes	No	Asthma	Yes	No	Drug Addiction	Yes	No	Kidney Disease
Yes	No	Blood Disease	Yes	No	Epilepsy or Seizures	Yes	No	Latex Allergy
Yes	No	Blood Transfusion	Yes	No	Glaucoma	Yes	No	Liver Disease
Yes	No	Bruise Easily	Yes	No	Hay Fever	Yes	No	Mental Disorders

Yes	No	Metal Allergy	Yes	No	Respiratory Issues	Yes	No	Sinus Problems
Yes	No	Mitral Valve Prolapse	Yes	No	Rheumatic Fever	Yes	No	Stroke
Yes	No	Pacemaker	Yes	No	Rheumatism	Yes	No	Thyroid Problems
Yes	No	Radiation Treatment	Yes	No	Sexually Transmitted Diseases	Yes	No	Ulcers

Please Circle Yes or No for the following:

1.Have you been recommended to take pre-medication before dental treatment by your physician? Yes No
2.Do you take or have you taken Bisphosphonates or bone density drugs? Yes No
3.Do you have shortness of breath upon waking from sleep? Yes No
4. Do you have shortness of breath when going upstairs? Yes No
5.Have you lost or gained or 10lbs or more in the last year? Yes No
6.Do your ankles swell during the day? Yes No
7.Are you allergic or sensitive to any medications or anesthetics? Yes No
Please list:_____
8.Have you been hospitalized or needed emergency care in the last 2 years? Yes No
If yes, please explain:
9.Do you have any health problems that need further clarification? Yes No
If yes, please explain:_____

10.Name of Physician_____Phone_____

CURRENT MEDICATION LIST:

1. ..... Taken for..... Dosage .....
2. ..... Taken for..... Dosage .....
3. ..... Taken for..... Dosage .....
4. ..... Taken for..... Dosage .....
5. ..... Taken for..... Dosage .....

Do you drink alcohol? If yes, how much? Frequency?	Yes	No
Do you smoke? If yes, how much?	Yes	No
History of use of recreational drugs or addiction?	Yes	No
FOR WOMEN ONLY		
Are you pregnant? Due Date:	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No

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.

X.....
Signature of patient, guardian or parent

X.....
Date

X.....
Reviewed by Doctor

X.....
Date

Date	Patient Initials	Dr. Initials	Health/Medication change	Dosage

Digital Communication Consent

Unencrypted email and text message is not a secure form of communication. There is some risk that any individually indentifiable health information and other sensitive or confidential information that may be contained in such email or text message may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email and/or text message from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

○ I consent to receiving appointment reminders and/or treatment information via email and/or text message. I understand I can withdraw my consent at any time.
My cell phone number is _____
My email address is _____

○ I do not consent to receiving any information via email. I understand I can change my mind and provide consent later.

_____ _____

Signature of Patient/Responsible Party Date

Our Office Policies

Tooth colored fillings: Your dental insurance carrier may not cover posterior composite fillings (tooth colored restorative material on back teeth) under the basic benefit as stated on your policy. Your dental carrier may pay based on the benefit of an amalgam or silver filling. Since silver fillings are not a regular alternative in this office, when you have a tooth colored filling placed, patient co-payments may be higher than estimated. Since the fees for this type of restoration are somewhat higher, patients should be aware of potential additional out of pocket expense.

Insurance: We understand the value of insurance benefits and will assist you in obtaining your maximum benefit. We will **estimate** your deductible and your co-payment and process your insurance claim for you. Your estimated portion is due at the time of treatment and may be paid by any of the following options listed below. Our estimates are not a guarantee of payment by your insurance company and could therefore change the amount due to our office. We agree to bill your insurance company as soon as our services are rendered. **Your co-payment is due at the time of your appointment.**

Payment Options:

1. Cash- this includes personal checks or money orders.
2. Major Credit Cards- Master Card, Visa, and American Express.
3. Interest free payment plan may be available (up to 18 months through outside lender) on credit approval. Application takes only a few minutes. We would be happy to work with you to plan the most appropriate course for your budget. Financing your treatment allows you to start dental care immediately and spread the payments over a time period appropriate for you.

Appointments: Please remember that your appointment has been reserved especially for you. If you find that you must change your appointment, we require a minimum of **24 hours notice to avoid a broken appointment fee.**

Failure to sign a service contract does not negate the patient's financial responsibility for any services that have already been rendered, as submission to treatment implies consent.

I have read and understand the above statements.

_____ _____

Signature of Patient/Responsible Party Date

I have received a copy of this office's Notice of Privacy Practices

_____ _____

Signature Date

I have received a copy of the Dental Materials Fact Sheet as required by law.

_____ _____

Signature Date

Patient Name _____ ☐ Male ☐ Female Marital Status (circle): single / married

Responsible Party Name: _____ Relation to Patient: ☐ Spouse/Partner ☐ Parent ☐ Other

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Birth Date: _____

Phone (Home): _____ Work): _____ (Cell): _____ Email: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Consent for Services

1. The undersigned hereby authorizes the Doctor to order x-ray, models, photos, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the Doctor chooses and employs such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself, or my dependants is due and payable when services are rendered. Please be advised that if any balance (either outstanding to insurance or to patient) is not received within 90 days of services rendered, a 1.5% finance charge or (18%APR) will be added to the account balance.
4. If you carry dental insurance, understand that this office will prepare and submit dental claims on your behalf. However this office does not assume that you're insurance will pay our charges in full.

***Please be advised that dental insurance is a contract between you and your dental carrier and is ultimately your responsibility.
In the event your carrier pays less than the estimated amount or denies any services, you are responsible for any unpaid balance.

Initial _____

I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor or responsible party _____ Date _____ Relationship to Patient _____