Bonita Grande Dental

PATIENT INFORMATION

Today's Date :

Patient's Name Last First MI (Preferred Name)

Home Address Street Apartment # City State Zip

Employer Occupation

Please Tick one: ☐ Single ☐ Married ☐ Separated ☐ Widow

Social Security # Birth Date / / Gender ☐ Male ☐ Female

Phone (Home): Work Ext (Cell)

Fax Other E-mail Adress

SPOUSE, PARENT OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the patient's parent/guardian ☐ the person responsible for payment ☐ Male ☐ Female

Name Employer

Social Security # Birth Date

Phone (Home): Work Ext (Cell)

Home Address Street Apartment # City State Zip

DENTAL INSURANCE INFOMATION (Primary Carrier)

Insured's name

Insured's employer

Insurance Co

Insurance Co Address

Phone #

SS # DOB

Group # Local

If you have digit insurance coverage, complete this for the second coverage

Insured's name

Insured's employer

Insurance Co

Insurance Co Address

Phone #

SS # DOB

Group # Local

Financial Policy

Thank you for choosing our office to provide your dental care. Our goal is to help you achieve and maintain optimum oral health by providing you with quality dental care. The following is a statement of our financial policy, which you must read, agree to, and sign before treatment is received. As a condition of your treatment at this office, financial arrangements must be made in advance. Payment is due at the time service is rendered. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and Care Credit. Outside financing is available upon request and approval.

Returned checks are subject to additional fees. If it becomes necessary for our office to enlist legal or collection services, you will be responsible for these collection or legal fees up to 35%.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. We will provide an insurance estimate. However, this is not a guarantee that your insurance will pay this exact estimate, as your insurance company and plan benefits ultimately determine the amount paid. The office will help prepare the patient's insurance forms or assist in making collection 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. All charges you incur are your responsibility regardless of your insurance coverage. Our relationship is with you, the patient, and not with your insurance company. We are not party to the contract you have with your insurance company.

We are strongly committed to providing the best treatment, and we charge what is usual and customary for the area. You are responsibly for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

By signing this form and any other forms required by your insurance company, we instruct your insurance company to make payments directly to our office.

At the time service is provided, we ask you pay your deductible and co-payment (the estimated amount not covered by your insurance company). This can be paid with cash, check, MasterCard, Visa, Discover, or Care Credit at the time service is rendered.

Typically, insurance payments are received within thirty to sixty days from the time of filing. If we have not received payment within sixty days, we will ask you to contact your insurance provider to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount due at this time.

We will fully cooperate with any regulations and requests made by your insurance company that will assist in the claim being paid; however, we will not enter a dispute with your insurance over any claim.

We are appreciative of the opportunity to provide your dental care and are more than happy to answer any questions or concerns you may have regarding your care or our financial policy.

Consent:
I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fees will be added to my overdue balance.

By signing below, you are authorizing us to call any number you provide, including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges you incur from an hincoming call from us, and/or outgoing calls to us, or from any such number, without reimbursement from us.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

Whom may we thank for referring you to our practice? ☐ Insurance ☐ Flyer ☐ Website ☐ Another Patient

☐ Walk in/Location ☐ Family Member ☐ Dental Office ☐ Yellow Pages ☐ Other ______________

Name of person or office referring you to our practice: ______________________________

Patient's Name: ____________________

DENTAL HISTORY

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Periodontal (gum) treatments	☐	☐

Please share the following dates:

- Your last cleaning ______ /______
- Your last oral cancer screening ______ /______
- Your last complete X-Rays ______ /______

Name of Previous Dentist ____________________

City ____________________ State ____________________

Phone Number ____________________

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐
How much?_______ For how long? _______		
If I could change my smile, I would:		
-Make it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? ____________________

____

What is the most important thing to you about your future smile and dental health? ____________________

What is the most important thing to you about your dental visit today? ____________________

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other ____________		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	____________		
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐	____________		
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐	____________		
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	____________		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO	
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐	Other ____________
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐	____________
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	____________

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

____

What medications are you currently taking?

____

Family Physician Phone Number

____

Consent:

The undersigned herby authorizes Doctor to take 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. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

____________________ ____________ ____________________

Patient Signature (Parent if child) **Date** **Dentist Signature**

Bonita Grande Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

____
{Please Print Name}

____
{Signature}

____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ___________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

______________________________ {Please Print Name}	______________________ Relationship
______________________________ {Please Print Name}	______________________ Relationship
______________________________ {Please Print Name}	______________________ Relationship

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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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