PRIMA DENTAL
YOUR SMILE COMES FIRST
1690 Woodside Rd. Suite 118
Redwood City, CA 94061

DOCTOR'S NOTES ONLY:

Medical Alert: ○Y ○N

NEW PATIENT INFORMATION PACKET

Date: _____

Patient's Full Name: _____ DOB: _____
Last First Middle Name Nickname preferred

PATIENT'S DENTAL HEALTH

What are your dental priorities ? _____ (e.g. appearance, dental health, financial consideration, etc.)

Please check all that apply:

- ☐ I clench or grind my teeth during the day or while sleeping
- ☐ I have problems eating
- ☐ I prefer tooth colored fillings
- ☐ My gums feel tender or swollen
- ☐ I like my smile
- ☐ I have had a facial or jaw injury
- ☐ My gums bleed while brushing or flossing
- ☐ I have had orthodontics
- ☐ I avoid brushing part of my mouth due to pain

PATIENT'S MEDICAL HISTORY

I consider my health to be (*please circle one*): ○ EXCELLENT ○ GOOD ○ FAIR ○ POOR

Do you have or have had any of the following ? *Please circle* **Y** for Yes or **N** for No

1.	○ Y	○ N	AIDS	30.	○ Y	○ N	Mental Disorder or Psychiatric Care
2.	○ Y	○ N	Allergies	31.	○ Y	○ N	Mitral Valve Prolapse
3.	○ Y	○ N	Anemia	32.	○ Y	○ N	Nervous Disorder
4.	○ Y	○ N	Arthritis	33.	○ Y	○ N	Osteoporosis
5.	○ Y	○ N	Artificial Joints	34.	○ Y	○ N	Pacemaker
6.	○ Y	○ N	Artificial Heart Valves	35.	○ Y	○ N	Pregnancy
7.	○ Y	○ N	Asthma	36.	○ Y	○ N	Respiratory Problems or Shortness of Breath
8.	○ Y	○ N	Blood Disease or Excessive Bleeding	37.	○ Y	○ N	Rheumatic Fever
9.	○ Y	○ N	Cancer_____	38.	○ Y	○ N	Rheumatism
10.	○ Y	○ N	Chemical Dependency	39.	○ Y	○ N	Scarlet Fever
11.	○ Y	○ N	Chemotherapy or Radiation Therapy	40.	○ Y	○ N	Shunts
12.	○ Y	○ N	Circulatory Problems	41.	○ Y	○ N	Sinus Problems
13.	○ Y	○ N	Cortisone Treatments	42.	○ Y	○ N	Skin Rash
14.	○ Y	○ N	Diabetes High or Low ?	43.	○ Y	○ N	Smoking of Tobacco Habit
15.	○ Y	○ N	Dizziness or Fainting	44.	○ Y	○ N	Stomach Problems or Ulcers
16.	○ Y	○ N	Dry Mouth	45.	○ Y	○ N	Stroke or Heart Attack If so how long ago_____
17.	○ Y	○ N	Epilepsy	46.	○ Y	○ N	Swelling of Feet or Ankles
18.	○ Y	○ N	Glaucoma	47.	○ Y	○ N	Thyroid Problems ☐ Hyperthyroid ☐ Hypothyroid ☐ Goiter
19.	○ Y	○ N	Headaches or Head Injuries	48.	○ Y	○ N	Tonsilitis
20.	○ Y	○ N	Hearing Problems	49.	○ Y	○ N	Turberculosis or Positive TB Skin test
21.	○ Y	○ N	Hemophilia	50.	○ Y	○ N	Tumors
22.	○ Y	○ N	Heart Disease	51.	○ Y	○ N	Veneral Disease
23.	○ Y	○ N	Heart Murmur	52.	○ Y	○ N	Vision Problems/Wearing Glasses or Contact Lenses
24.	○ Y	○ N	Hepatitis A, B or C				
25.	○ Y	○ N	High Blood Pressure				
26.	○ Y	○ N	HIV				
27.	○ Y	○ N	Kidney Disease				
28.	○ Y	○ N	Liver Disease				
29.	○ Y	○ N	Low Blood Pressure				

Are you allegic to any of the following ?

53.	○ Y	○ N	Aspirin
54.	○ Y	○ N	Barbiturates (Sleeping Pills)
55.	○ Y	○ N	Codeine Allergy
56.	○ Y	○ N	Latex Allergy
57.	○ Y	○ N	Local Anesthetic Allergy
58.	○ Y	○ N	Penicillin Allergy
59.	○ Y	○ N	Phen Phen Allergy
60.	○ Y	○ N	Sulfa Allergy

Are you taking any of the following for osteoporosis ?

61.	○ Y	○ N	Fosamax
62.	○ Y	○ N	Boniva
63.	○ Y	○ N	Reclast
64.	○ Y	○ N	Actonel
65.	Other_____		

Women Only

66.	○ Y	○ N	Birth Control Medication
67.	○ Y	○ N	Pregnant or Nursing ?

68. Do you have any other medical problems or medical history NOT listed on this form ?
○ Y ○ N

_____
_____
_____
_____
_____

Please list all medications you are currently taking:

Physician's Name: _____ Phone #: _____

Address: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

PATIENT'S CONSENT

1. I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis of my 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 in connection with my treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed appropriate to provide the recommended treatment.
3. I understand that it is my responsibility to advise the doctor's office of any changes in the information contained on this form.
4. 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.

_____ _____

Signature of Patient or Parent if Minor Date

_____ _____ _____

Signature of Doctor License Number Date

PATIENT'S HEALTH HISTORY UPDATES

Date:	Changes:	*Please initial* Patient	Doctor
		License#	
		License#	
		License#	
		License#	
		License#	
		License#	

PATIENT INFORMATION and AGREEMENT *(please print)*

Date: _____

Patient's Full Name: _____ _____
Last First Middle Name Nickname preferred

GETTING TO KNOW YOU AS OUR PATIENT

2. Sex: ☐ M ☐ F
3. Date of Birth: _____ Age: _____
4. Social Security#: _____
5. CDL#: _____
6. Home Address: _____
City, State, Zip: _____
7. Phone/Cell: _____ Work#: _____
8. Email: _____
9. Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep.
Spouse Name: _____
10. Patient's Employer: _____
Employer's Address: _____

RESPONSIBILITY PARTY

11. Name of Responsible Party: _____ 12. Realationship to you: _____ 13. CDL#: _____
13. Employer of Reponsible Party (name and address): _____
14. DOB: _____ 15. SS#: _____

PPRIMARY INSURANCE COVERAGE (attach copy of card)

16. Insurance Company: _____
Phone: _____
17. Subscriber's Name: _____
18. Subscriber's Sex: ☐ M ☐ F
19. Subscriber's Date of Birth: _____
20. Subscriber's Social Security#: _____
21. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
22. Subscriber's Employer: _____
23. Subscriber's ID#: _____
24. Group#: _____

SECONDARY INSURANCE COVERAGE (attach copy of card)

25. Insurance Company: _____
Phone: _____
26. Subscriber's Name: _____
27. Subscriber's Sex: ☐ M ☐ F
28. Subscriber's Date of Birth: _____
29. Subscriber's Social Security#: _____
30. Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
31. Subscriber's Employer: _____
32. Subscriber's ID#: _____
33. Group#: _____

How did you hear about our office ? *(check only one)*

☐ Referred by a friend	☐ Insurance plan	☐ TV/Radio Ad
☐ Other (Social Media)	☐ Direct Mailing	☐ Newspaper Ad
☐ Relative	☐ Yellow Pages	☐ Sign by building

AGREEMENT TO PAY

I agree for all services rendered on my behalf of my dependents. In the event that payment is not made within (30) days of receipt of statement, a service charge at the legal rate may be added to the past due balance. If collection services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. I certify that all information is complete and correct. Prima Dental office may verify this information from which ever sources it deems necessary including but not limited to a consumer report which may contain records information. All fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. **I understand that dental insurance is a contract between the patient and the insurance carrier, and NOT between the insurance carrier and the dentists.**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and the use of this signature on all insurance submissions.

I also acknowledge that I have received a copy of the Dental Materials Fact Sheet dated 2004.

Signature of Patient or Parent if Minor	Date	Relationship to Patient

FINANCIAL POLICY

We welcome you to our family of dental care providers and we are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept most insurances, Cash, Checks, Visa, Master Card, American Express, Discover or we offer a few Payment Plans which allows low monthly payments with prior credit approval.

For your convenience, we offer the following methods of payment. Please check the method of payment you wish to choose to settle your account:

☐ I have insurance ☐ Cash or Check

☐ Credit Card ☐ I'd like to know more about your payment plans

Regarding insurance:
We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have complete insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance becomes your responsibility. Your insurance policy is a contract between you and and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be cleared in less than 45 days.

Usual and Customary Rates:
Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determinations of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing:
For all accounts over 45 days with patients' amounts due, there will be a $10.00 billing fee or a finance charge of 1.5% per month, whichever is more. We assign all accounts over 120 days to a collection service for processing.

Should this account become past due, you agree to pay reasonable additional fees, including any and all collection agency, legal fees and/or court cost, necessary to collect this amount.

I agree to this financial policy, and I have read and received a copy of this statement.

THERE WILL BE A CHARGE OF $100.00 FOR CANCELLING ANY APPOINTMENT WITHOUT 48 HOURS NOTICE OR FOR FAILING TO SHOW FOR AN APPOINTMENT.

Patient Signature **Parent/Guardian Signature**

Date _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"you may refuse to sign this acknowledgement"
We are not able to bill your insurance without your signature

I, _____ have received a copy of the office's Notice of Privacy Practices.

_____
Print Name

_____ _____
Patient Signature Parent/Guardian Signature

Date _____ Date _____

_____
We attemp to obtain written acknowledgement of receipt of our Notice of Private Practices, but acknowledgement could not be obtained because:

____☐____ Individual refused to sign

____☐____ Communication barrier prohibited obtaining the acknowledgement

____☐____ An emergency situation prevented us from obtaining acknowledgement

____☐____ Other (specify below):

_____

_____

_____