CALAVERA HILLS DENTAL

Patient Information

Patient Name:_____ Date: _____
First Last MI

☐ Male ☐ Female ☐ Married ☐Single ☐Child Email : _____

Social Security # _____ Date of Birth:_____

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

Best way to contact you: ☐Home phone ☐Cell Phone ☐ Work Phone ☐ Email

Address:_____
Street Apt #

_____
City State Zip Code

Reason for today's visit _____ Date of Last Dental Visit:_____

How did you hear about our office?_____

Have you ever had any of the following? Please check Yes or No: **DR'S INITIALS :** _____

	YES	NO		YES	NO		YES	NO
Penicillin Allergy			**Epilepsy**			**Radiation Treatment**		
Codeine Allergy			**Excessive Bleeding**			**Respiratory Problems**		
Sulfa Allergy			**Fainting**			**Rheumatic Fever**		
Other Allergies			**Glaucoma**			**Rheumatism**		
			Head Injuries			**Sinus Problems**		
AIDS			**Heart Disease**			**Stomach Problems**		
Anemia			**Heart Murmur**			**Stroke**		
Arthritis			**Hepatitis**			**Tuberculosis**		
Artificial Joints			**High Blood Pressure**			**Ulcers**		
Asthma			**Kidney Disease**			**For Women Only:**		
Blood Disease			**Liver Disease**			**Are you pregnant?**		
Cancer			**Mental Disorders**			**Are you nursing?**		
Diabetes			**Nervous Disorders**			**Are you on birth control?**		
Dizziness			**Pacemaker**					

- Are you taking any medications? ☐Yes ☐ No If yes, please list them_____
  _____
- Have you every had any complications following dental treatment ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to the hospital or needed emergency care during the past two years ☐ Yes ☐ No
  If yes please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking, or have you ever taken, bone density meds. or bisphoshonates such as Fosamax, Boniva, Actonel, IV-Zometa, Prolia, or Aredia in the past 12 years? ☐ Yes ☐ No

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health I will inform the doctors at the next appointment without fail. ☐ I would like a copy of this completed form for my files. I have received a copy of the Dental Materials Fact Sheet as required by law. I hereby acknowledge that I have received a copy of this practice's HIPPA notice or privacy practices. I've been given the opportunity to ask any questions I may have regarding this notice.

_____Date _____
Signature of patient, parent or guardian

Responsible Party Information
(Please fill this out if someone other than the patient will make payment)

Name: _____ Relation: _____

Social Security # _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Insurance

Name of Subscriber: _____ is Subscriber a patient? ☐ Yes ☐ No

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

Insured's Address: _____
(if different from patient) Street City State Zip Code

Insured's Employer Name: _____

Patients relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Patient Employment Information

Employer Name: _____ Occupation_____

Address: _____
Street City State Zip

Secondary Insurance

Name of Subscriber: _____ is Subscriber a patient? ☐ Yes ☐ No

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patients relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Terms for Services

All fees are due and payable on the day of service. As a condition of your treatment by this office, any financial arrangements must be made in advance.

48 HOUR WEEKDAY NOTICE IS REQUIRED FOR APPOINTMENT RE-SCHEDULES/ CANCELLATIONS TO AVOID CANCELLATION FEES.

Missed appointments: First missed appointment no charge. Second missed appointment $25 charge. Third plus missed appointments you will be charged $100 and will be required to make an additional $100 deposit to schedule any future appointments.

I understand that the fee estimate listed for this dental care can only be extended for a period of one year from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home, work or at my cell # to discuss matters related to my treatment.

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

_____ Date_____ Relationship to patient _____
Signature of patient, parent or guardian

_____ Date_____ Relationship to patient_____
Signature of guarantor of payment/responsible party