ALAMEDA DENTAL CARE

**Who may we thank for referring you to our office?** _____ Today's Date_____

## Patient Information

Patient Name: _____Preferred Name: _____ Date of Birth:_____ Gender: M/F

Mailing Address: _____ City: _____State: _____ Zip: _____ SS#: _____

Home Phone: _____Work Phone: _____Cell: _____ Marital Status: _____

E-Mail: _____@_____ Employer: _____Occupation:_____

Employer Address: _____ Employer Phone: _____

Emergency contact: _____Relationship: _____Phone: _____ Phone: _____

## Primary Insurance Information

Subscriber's Name: _____Date of Birth: _____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St: ____ Zip: _____ Phone:_____

## Secondary Insurance Information

Subscriber's Name: _____Date of Birth: _____ Employer: _____

SS#: _____ ID #_____ Name of Insurance Company: _____

Insurance Address: _____City: _____St: _____ Zip: _____ Phone:_____

**Would you like email and text reminders? Email Y/N Text Y/N**

### ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

**HIPAA.** I acknowledge that I have been offered a copy of Alameda Dental Care Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name _____ Signature _____

Relationship to Patient_____ Date _____

# OFFICE POLICY

Welcome to Alameda Dental Care! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

**Insurance:** Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. Initials_____

**Payment** from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial down-payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

**Copyright:** Any comment posted online in any way relating to Alameda Dental Care, doctors or employees will be the sole right and property of Alameda Dental Care and the copyright of the content of the comment, rating, or review is hereby assigned to Alameda Dental Care to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. We appreciate public praise and comments and reviews.

Initials_____

**Payment:** Payment in full is required at the time of service. For your convenience, we accept checks, debit, and credit cards, including Visa, Mastercard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit or CitiHealth. Initials _____

**Estimates:** Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. Initials_____

**Aged Account:** The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Alameda Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. Initials____

**Appointments:** If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 per hour. Initials_____

**Assignment of Benefit:** I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Alameda Dental Care.

I have read, understand, and agree to the above.

_____

Signature of Person Responsible for Account

_____ _____

Printed Name of Person Responsible for Account Date

***Are you aware of the link between the bacteria in your mouth and your overall health?***

| Dental History | Yes | No |
|---|---|---|
| Are your teeth sensitive to (circle which apply): | | |
| Heat Cold Sweets Pressure | | |
| If yes, please explain: | | |
| | | |
| | | |
| Does food catch between your teeth? | | |
| If yes, please state location: | | |
| Do your gums bleed when brushing or flossing? | | |
| Do you feel you have bad breath? | | |
| Have you ever had a "deep cleaning" (below your gums and usually requiring | | |
| local anesthetic)? | | |
| Do you have any problems with your jaw joint (TMJ)? | | |
| Clicking? | | |
| Jaw Pain (Joints, ear side of face)? | | |
| Difficulty chewing? | | |
| Locking open or closed? | | |
| Headaches when awakening? | | |
| Have you ever had an adverse reaction to anesthetics? | | |
| If yes, please describe: | | |
| | | |
| Do you currently or have you ever used tobacco products? | | |
| If yes, please circle: cigarettes chewing tobacco vaping e-cigarettes smoking marijuana | | |
| When was your last oral cancer screening? | | |
| Do you have any lumps, bumps, or sores in your mouth that have not healed within 10 days? | | |
| If yes, please state location: | | |
| Do you have missing teeth? | | |
| If so, how long have they been missing? | | Years |
| Rate your smile on a scale of 1-10 | | |
| What would make your smile a 10? | | |
| Why did you leave your last dentist? | | |
| When was your last dental appointment? | | |
| When was your last dental cleaning? | | |
| Have you ever have orthodontic treatment? | | |
| Rate your anxiety you have about dental treatment 1-10 | | |
| Are you interested in learning more about sedation options for dental care? | | |
| What is your chief dental concern? | | |
| What can we do to make your appointment more comfortable? | | |

| Health History | Yes | No | Date Diagnosed |
|---|---|---|---|
| Are you under a physician's care at this time? | | | |
| If yes, please explain and list the name and phone number for your MD: | | | |
| Have you ever been treated for a bone disorder (ie osteoporosis)? | | | |
| Have you ever been treated for any kind of cancer? | | | |
| If so, have you ever received radiation and/or chemotherapy? | | | |
| Do you have any conditions that require Pre-Medication? | | | |
| If yes, please explain: | | | |
| Do you take blood thinners? | | | |
| Do you have or have you ever had: | | | |
| Respiratory Conditions, including asthma? | | | |
| Thyroid problems? | | | |
| Epilepsy? | | | |
| Stroke? | | | |
| High or Low Blood Pressure? | | | |
| Pacemaker? | | | |
| Heart Disease ? | | | |
| Heart Attack? | | | |
| Acid Reflux? | | | |
| STDs? | | | |
| Hepatitis (Please circle) A B C | | | |
| HPV? | | | |
| HIV/AIDS? | | | |
| Do you get cold sores | | | |
| Have you been told, or notice, that you snore at night? | | | |
| Are you tired, fatigued, or sleepy on most days? | | | |
| Drug Allergies? Please list: | | | |
| Are you diabetic? If yes, please circle: Type I or Type II | | | |
| Is your diabetes well controlled? | | | |
| Do you have a sugar source with you at all times? | | | |
| Did you know there is a direct link between diabetes and gum disease? | | | |
| Women: | | | |
| Are you pregnant? | | | |
| Are you nursing? | | | |
| Are you taking birth control pills? | | | |
| Please list all medications you are taking including over the counter medications: | | | |

By signing below you acknowledge you have provided an accurate health history to your dental office. Please keep your dental team informed of any changes in your health as changes can affect your oral health. Additionally, many diseases first symptoms present in the oral cavity and you may be asked to see your medical doctor for diagnosis.

Signature of Patient or Legal Guardian of Patient

Date

Patient Printed Name

Printed Name of Guardian

Provider Reviewed and Date

To be taken by Health Care Professional:
Initial BP_____ and HR_____