PATIENT INFORMATION

Email: _____

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Address: _____
Street City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer's Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

INSURANCE INFORMATION OF SELF, SPOUSE OR RESPONSIBLE PARTY

Primary

Name of Insured: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

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

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: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

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

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: _____

_____

CONSENT FOR SERVICES / ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Novato Dental Care** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I consent to the diagnostic procedures, including x-ray procedures and photographs, and treatment by the dentist necessary for proper dental care.

_____ Date: _____ Relationship: _____
Signature of patient, parent or guardian

Patient's Name: _____ Date of Birth: _____

DENTAL HISTORY

What is the reason for your visit today? _____

Do you have any dental problems at this time? ☐ **Yes** ☐ **No**

If yes, please describe _____

Please share the following dates:

Your last cleaning ____/____

Your last complete X-Rays ____/____

How often do you brush your teeth?_____ **Floss?**_____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Dry Mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

May we send for your dental records? ☐ **Yes** ☐ **No**

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

MEDICAL HISTORY

Are you required to take an antibiotic/pre-med before a dental visit? ☐ **Yes** ☐ **No**

Please check Yes or No for any of the following that applies to you.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Allergies(Seasonal)	☐	☐	Heart Conditions	☐	☐	Radiation (head/neck)
☐	☐	Anemia	☐	☐	Heart Lesions (congenital)	☐	☐	Respiratory Problems
☐	☐	Arthritis	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Artificial Heart Valve	☐	☐	Heart Surgery	☐	☐	Rheumatism
☐	☐	Artificial Joints	☐	☐	Hepatitis A	☐	☐	Scarlet Fever
☐	☐	Asthma	☐	☐	Hepatitis B	☐	☐	Seizures
☐	☐	Blood Disease	☐	☐	Hepatitis C	☐	☐	Stomach Problems
☐	☐	Bruise Easily	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Cancer	☐	☐	HIV Positive	☐	☐	Sinus Trouble
☐	☐	Chemotherapy	☐	☐	Jaundice	☐	☐	Thyroid Diseases
☐	☐	Cold Sores	☐	☐	Jaw Joint Pain	☐	☐	Other
☐	☐	Diabetes	☐	☐	Kidney Disease			
☐	☐	Drug Addiction	☐	☐	Liver Disease			
☐	☐	Emphysema	☐	☐	Low Blood Pressure			
☐	☐	Excessive Bleeding	☐	☐	Mitral Valve Prolapse			
☐	☐	Fainting	☐	☐	Nervousness/Depression			
			☐	☐	Pacemaker			

Are you taking any of the following medications?

Yes	No	
☐	☐	Diphosphonate
☐	☐	Fosamax
☐	☐	Phen Fen/Diet Pills(1mo+)
☐	☐	Recreational Drugs

Do you have any of the following drug allergies?

Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Metal
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Local Anesthetic	☐	☐	Sulfa Drugs
☐	☐	Latex	☐	☐	Other

Important! Women: Are you

Pregnant/trying to get pregnant? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

How much? _____For how long? _____

Are you under a physician's care? ☐ Yes ☐ No

If yes, what for? _____

Have you been hospitalized in the last three years? ☐ Yes ☐ No

If yes, why? _____

Are you taking any medications, over-the-counter medicines (including Aspirin)? ☐ Yes ☐ No

If yes, please list medications: _____

_____

Family Physician: _____ Phone: _____

Contact in case of emergency: _____ Phone: _____

Is there any other medical or dental information we should know about? _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my Dentist of any change in my health and or medication.

Patient's Signature: _____ Date: _____

Patient: Print Full Name: _____

Insurance and Financial Policy

At Novato Dental Care, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation.

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

_____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

_____ We accept cash, personal checks, debit card, Master Card, Visa, Discover Card, and American Express. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, or 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Outstanding balances older than 90 days are subject to finance charges at the rate of 1.5% monthly. Returned checks are subject to a $25 administrative fee in addition to any outstanding amount. In the unfortunate event that your account needs to be forwarded to a collection agency you will be responsible for your outstanding balance, accrued interest, and any collection agency charges that may be imposed.

_____ Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges on all accounts for which you serve as the guarantor are your responsibility from the date the services are rendered. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

_____ You may direct the insurance company to pay their share of the cost directly to our office (Assignment of Benefits). Often, we do not receive these payments until two to three months after being submitted for payment therefore you will be required to pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment we will reconcile your account and bill or refund any difference. In the event that your insurance company does not pay within 90 days of rendering treatment, please understand that the guarantor of your account is not responsible for this outstanding balance.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $30/hour cancellation fee (emergencies are an exception).

I agree with the above conditions.
Print Name:_____ Date:_____

Patient/Parent Signature: _____

Novato Dental Care, 1744 Novato Blvd, Ste 110, Novato, CA 94947

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CALIFORNIA DENTAL MATERIALS FACT SHEET

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

I, _____, have received a copy of the *California Dental Materials Fact Sheet.*

Signature Date

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specifiy)