PATIENT INFORMATION FORM

APPT DATE_____@_____

Date_____Patient Name_____Nickname_____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth_____SS#_____Driver's License #_____

Address_____Apt#_____City & Zip_____

Phone #_____Cell Home Another Phone #_____ Cell Home

Patient Employed by_____ Occupation_____

Email_____

How did you learn about our office? Phone Book Insurance web site 1800DENTIST Internet Search Drive By Other

If a person referred you please give us that person's name_____

RESPONSIBLE PARTY IF A DEPENDENT CHILD OR ☐ check here if same as above

Is patient a minor? ☐Yes ☐No Full-time Student? ☐Yes ☐No Name of School_____

Name of Responsible Party: _____

Address_____Apt#_____City & Zip_____

Phone #_____Cell Home Another Phone #_____ Cell Home

Relationship to Patient ☐Parent ☐ Spouse ☐ Other

If patient is a minor, primary residency ☐Both Parents ☐Mom ☐Dad ☐Step Parent ☐Shared Custody ☐Guardian

DENTAL BENEFIT PLAN INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Insured_____Date of Birth_____

Employer_____Occupation_____

Primary Dental Insurance Company _____Phone_____

Insurance ID or SS # _____Group or Plan Number _____

SECONDARY INSURANCE INFORMATION

Name of Insured_____Date of Birth_____

Employer_____Occupation_____

Secondary Dental Insurance Company_____Phone_____

Insurance ID or SS # _____Group or Plan Number_____

CONFIDENTIAL MEDICAL AND DENTAL HEALTH HISTORY

PATIENT'S NAME_____DATE OF BIRTH_____

1. Reason for this visit_____
2. When was your last dental visit?_____
3. Name and phone number of previous dentist_____

I. PLEASE CIRCLE YES TO THOSE THAT APPLY

My gums bleed when I brush	yes	I clinch or grind my teeth	yes
I have clicking in my jaw joint	yes	I have had difficulty with extractions	yes
I have difficulty opening or closing	yes	I have had prolonged bleeding from extractions	yes

II. DO YOU HAVE ANY MENTAL CONDITON? CIRCLE ALL THAT APPLY

Anxiety	Autism	ADD
ADHD	Downs Syndrome	Dementia
Developmental Delayed	Bipolar	Depression
Panic Disorder	Phobias	PTSD
OCD		

Other – Please explain_____

III. Circle appropriate answer

1. Yes / No Is your general health good?
   If NO, explain_____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain_____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain_____
4. Yes / No Are you being treated by a physician now?
   If YES, explain_____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain_____
6. Yes / No Are you in pain now?
   If YES, explain_____
7. Yes / No Have you ever been pre-medicated for dental treatment?
   If YES, why_____
8. Yes / No Do you snore? Yes/No Have you had a sleep study? Yes/No
   If YES, when_____
9. Yes / No If YES, Were you diagnosed with Sleep Apnea?
   If yes, do you wear a C.P.A.P? Yes/ No
10. Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?

IV. Have you taken any of the following in the last three months? (circle yes or no for each)

Yes / No	Antibiotics	Yes / No	Recreational drugs	Yes / No	Psychiatric drugs
Yes / No	Aspirin	Yes / No	Over the counter medications	Yes / No	Alcohol
Yes / No	Anti-depressants	Yes / No	Corticoid - Steroids	Yes / No	Supplements
Yes / No	Fossamax/Boniva	Yes / No	Tobacco in any form	Yes / No	Weight loss medication

Please list the prescriptions medications that you take_____

_____

V. Are you allergic to or have you had a reaction to any of the following (circle yes or no for each)

Yes / No Aspirin
Yes / No Codeine
Yes / No Darvon
Yes / No Local Anesthetic (Novacain or Xylocaine)
Yes / No Food
Yes / No Erythromycin
Yes / No Demerol
Yes / No Latex
Yes / No Penicillin/amoxicillin
Yes / No Percodan
Yes / No Tetracycline
Yes / No Valium
Yes / No Vicodin
Yes / No Metal/nickel

Other allergies_____

VI. Do you CHRONICALLY experience any of the following? (circle yes or no for each)

Yes / No Chest pain (angina)
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficultly urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problem

VII. Have you had or do you have any of the following? (circle a yes or no for each)

Yes / No Acid reflux
Yes / No Anemia
Yes / No Artificial joint
Yes / No Asthma
Yes / No Auto immune disease
Yes / No Blood pressure – high low
Yes / No Cancer / tumors
Yes / No Canker or cold sores
Yes / No Chemotherapy
Yes / No Cosmetic surgery
Yes / No Dental anxiety
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Eating disorders
Yes / No Emphysema
Yes / No Epilepsy/Seizures
Yes / No Eye disease
Yes / No Hardening of arteries
Yes / No Heart attack
Yes / No Heart defects
Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart murmurs
Yes / No Heart MVP
Yes / No Heart pacemaker
Yes / No Heart surgery
Yes / No Hepatitis A B C
Yes / No Herpes
Yes / No HIV/AIDS
Yes / No Hives/skin rash
Yes / No Hospitalization
Yes / No Hypoglycemia
Yes / No Kidney/bladder disease
Yes / No Liver disease
Yes / No MS
Yes / No Osteoporosis
Yes / No Radiation therapy
Yes / No Rheumatic fever
Yes / No Sexually transmitted disease
Yes / No Skin disease
Yes / No Stroke
Yes / No Surgeries
Yes / No Thyroid disease
Yes / No Tonsillitis
Yes / No Transplants
Yes / No Tuberculosis
Yes / No Ulcers/stomach disease
Yes / No Vertigo

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If, YES, explain_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician Name_____Phone Number_____

I certify that I have read and understand this form. 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 medications. Furthermore, I will not hold my dentist or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____Date_____
Patient (or parent or guardian of minor child)

Dentist Signature_____Date_____

VIII. Women only

Yes / No Are you or could you be pregnant? If yes what month?_____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

PRACTICE POLICIES CONSENT FOR SERVICES AND ACKNOWLEDGEMENT OF OFFICE POLICIES, PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET

1. 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.
2. The undersigned hereby authorizes doctor to order 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.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with my treatment or my child's treatment.
4. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance, as deemed fit, to provide recommended treatment.
5. PROSTHETICS: Crowns, Dentures, Bridges, etc, Failure by member to return for the delivery of these items is subject to doctor time and lab fee charges. MUST INITIAL HERE_____
6. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient. The costs incurred for their care and financial responsibility on the part of each patient must be determined before treatment.
7. I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. A service charge of 1 ½% per month (18% per annum) on unpaid balances will be charged on all accounts exceeding 90 days. All patient with a balance on the account will receive a billing statement, regardless of insurance. I give permission to Vimala Vontela, DDS to email statements to me for any balance.
8. I understand that where appropriate, credit bureau reports may be obtained.
9. Collection fees: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred. MUST INITIAL HERE_____
10. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections 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. Furthermore, I hereby authorize payment directly to Vimala Vontela, DDS of the group insurance benefits otherwise payable to me.
11. I authorize the use of my social security number to file my dental claims in the event I cannot provide an insurance identification number. I also acknowledge I need to provide the office a copy of my California state driver's license.
12. I understand it is my responsibility to advise your office of any changes in the information contained on this form. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my dental care.
13. I understand the office requests a 48 hour notification in the event an appointment must be rescheduled and requires a 24 hours notice or a charge may be incurred. MUST INITIAL HERE_____
14. I acknowledge I have received or have access to the office's Notice of Privacy Practice and a copy of the Dental Material Fact Sheet.
15. I have read the above conditions and agree to the content.
16. May we leave messages on your phone regarding your dental care and appointment times?
    Home phone YES NO CELL PHONE YES NO

X _____

Signature of guarantor of payments and/or patient, parent or guardian Date Relationship to patient