Randall Stettler, D.D.S, Inc

5565 Grossmont Center Dr, Building 1 Suite 129, La Mesa, CA 91942 (619) 463-4486

PATIENT INFORMATION

Last Name **First Name** **Middle Initial**

*If Patient is a child, Parent/guardian's Name

Resident Address **City** **State** **Zip**

Sex: **M F** Home Telephone # ( )-_____-_____ Cell # ( )-_____-_____

Work # ( )-_____-_____ Can we contact you by email? Y N Email Address: _____

_____/_____/_____ S M D W _____/_____/_____ _____

Date of birth **Marital Status** **Social Security #** **Occupation**

Name of School/Employer: _____

Emergency Contact: _____ Phone: ( ) _____

Referred By: _____

Why did you select our Office? _____

What did you like the most about any dentist you've ever seen? _____

_____

What did you like the least about any dentist you've ever seen? _____

_____

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MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____
Age: _____ Weight: _____ Height: _____ Your Dentist: _____
Your Medical Dr: _____

Yes No Have you been a patient in the hospital or under the care of a medical doctor during the past two years? For what? _____

Yes No Have you had surgery in the last 10 years? For what? Any reaction to medications or anesthesia? If so what?
_____

Yes No Are you **allergic to** (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by latex, **any drug**, or medication? **If so, what? What is the reaction?**
_____

Yes No When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are tired?

Yes No Have you gained or lost more than 10 pounds in the past year?

Yes No Are you currently or have taken **BISPHOSPHONATE** medications? **If so, what kind and when?**_____

Y N Heart Failure
Y N High Blood Pressure
Y N Heart Disease
Y N Angina (chest pain)
Y N Heart Murmur
Y N Pre-Med for Surg.
Y N Heart Lesions
Y N Artificial Heart Valve
Y N Heart Pacemaker
Year _____
Y N Heart Surgery
Year _____
Y N Cortisone Medicine
Y N Anemia
Y N Rheumatic Fever
Y N Rheumatism
Y N Drink Alcohol – How often? _____

Y N Sickle Cell
Y N Bruise/Bleed Easily
Y N Pain in Jaw Joints
Y N Emphysema
Y N Asthma
Y N Cough
Y N Tuberculosis (TB)
Y N Stroke
Y N Chemotherapy
Y N Epilepsy
Y N Glaucoma
Y N Swollen Ankles
Y N Diabetes
Type _____
Y N Arthritis
Y N Contact Lenses

Y N Thyroid Disease
Y N Allergies or Hives
Y N Hay Fever
Y N AIDS
Y N AIDS Related Comp
Y N Liver Disease
Y N Hepatitis
Type _____
Y N Yellow Jaundice
Y N Kidney Trouble
Y N Fainting
Y N Cancer / Tumor
Type _____
Y N Breathlessness
Y N Smoke
for How long _____

Y N Artificial Joints
Y N Psychiatric Treatment
Y N Nervousness
Y N Recreational Drug Use
for how long_____
Y N Sinus Trouble
Y N Taken Phen-fen
Y N Radiation Treatment
Y N Special Diet
Y N Blood Transfusion
Year _____
Y N Hemophilia
Y N Nasal Polyps
Y N Sleep Apnea
Y N Snore
Y N Ulcers

Women: Y N Are you pregnant?
Y N Is there a possibility you are pregnant?
Y N Are you nursing?

Yes No Do you have any disease, condition, or problem not listed? _____
_____

To the best of my knowledge, all the preceding answers are true and correct. If there is any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail

_____ _____
Date Signature of patient, parent or guardian

Doctor:_____

HEALTH / MEDICINE / MEDICATION ALLERGY HISTORY

Medicine Allergies with the Reaction

Allergy ☐ None ☐ See Attached Sheet	Reaction

Prescription Drugs, Diet/Weight Loss Medicines, Over the counter Medicines, Herbal/Holistic Remedies, Vitamins, Supplements & Minerals

Medication ☐ None ☐ See Attached Sheet	Dosage	Frequency	Prescribing Doctor

I understand the importance of a truthful and complete Health History to assist my surgeon in providing the best care possible. If I have not completed the list, I have completed it to the best of my ability, and am unable to provide any further information. I also give my consent to my surgeon to obtain any medical records or laboratory tests deemed pertinent to my evaluation and treatment.

Date _____ Signature of Patient/Guardian Completing Health History _____ Doctor's Initials _____

PLEASE EDIT HEALTH HISTORY IF THERE HAS BEEN ANY CHANGES AND RESIGN, OR RESIGN TO VERIFY THAT THERE HAS BEEN NO CHANGES TO YOUR HEALTH HISTORY. YOU WILL NEED TO FILL OUT A NEW HEALTH HISTORY IF IT IS GREATER THAN ONE YEAR OLD.

Date _____ Signature of Patient/Guardian Completing Health History _____ Doctor's Initials _____

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Date _____ Signature of Patient/Guardian Completing Health History _____ Doctor's Initials _____

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WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

Name: _____ Relationship _____

Sex: M F Date of Birth: _____ SSN: _____

Street Address:_____

City: _____ State: _____ Zip: _____

Insurance

*** Primary Insurance:** _____ Insured DOB: _____

Name of Insured: _____ Insured ID#: _____

Group/Policy Number: _____ Relationship to patient: _____

Policy Holders Employer: _____

*** Secondary Insurance:** _____ Insured DOB: _____

Name of Insured: _____ Insured ID#: _____

Group/Policy Number: _____ Relationship to patient: _____

Policy Holders Employer: _____

*** Medical Insurance:** _____ Insured DOB: _____

Name of Insured: _____ Insured ID#: _____

Group/Policy Number: _____ Relationship to patient: _____

Policy Holders Employer: _____

FOR ALL PATIENTS

In order to establish optimal relations with patients and avoid misunderstanding regarding our payments policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICES FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, DISCOVERY, AND AMERICAN EXPRESS FOR YOUR CONVIENCE**.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered. I agree to pay all the fees and charges for the services rendered at the time of treatment. After your insurance has paid we request payment of the balance within 15 days unless other arrangements are made. Interest of 18% APR (1.5 monthly) is charge on all balances 60 days past due of service. I hereby authorize the doctor to perform any and all forms of treatment, medication, the therapy, that maybe indicated in the connection with the dental care of the patient above and further authorize and consent that the doctor may choose and employ any assistance as he deems fit. I also understand that prior to the treatment, the Doctor and/or staff will give a full explanation of the procedure(s) involved. I also understand that I am Responsible for any amounts not paid by my Insurance Company. I agree to pay all attorney fees and cost incurred by this office to collect any unpaid balance.

Signature of Responsible Party: _____ **Date**: _____

Should the account fall into the arrears greater than 60 days; I authorize that unpaid balance to be charged to my major credit card, as listed below.

Visa Mastercard Discovery American Express

Card Number _____ Expiration Date _____ / _____

Name as it appears on Card _____

Signature_____**Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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}

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

Consent for Use and Disclosure of Health Information

USE OF THIS FORM IS OPTIONAL

Purpose: In cases where Dr. Randall W. Stettler_ has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Dr. Randall Stettler Oral and Maxillofacial Surgery Center

Telephone: (619) 463-4486 Fax: (619) 463-6553

E-mail: randallstettlerdds@gamil.com

Address: 5565 Grossmont Center Dr, Building #1, Suite #129 La Mesa, CA 91942

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and heath care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____