J.R. Pulido, DDS

Patient Information

Patient Name: _____ Date: _____
Last First MI
__ Male __ Female __ Married __ Single __ Child __ Other ___
Birth Date: _____ Social Security #: _____
Address: _____
Street Apartment #
_____
City State Zip Code
Phone (Home): _____ (Work): _____ Ext: ____ Best time to call _____
Cell Phone: _____ Email Address: _____

Referral Information

Whom may we thank for referring you to our practice? __ Another patient __ Relative
__ Friend __ Website __ Dental Office __ School __ Work __ Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: __ the patient's spouse __ the person responsible for payment
Name: _____
__ Male __ Female __ Married __ Single __ Child __ Other
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext.: _____ Best time to call: _____
Address: _____
Street Apartment #
_____
City State Zip Code

Employment Information

The following is for: __ the patient __ the person responsible for payment
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code
If you are a student, name of school/college: _____

Insurance Information

Primary
Name if insured: _____Is insured a patient? __Yes__No
Last First MI
Insured's Birth Date: _____ ID# _____ Group# _____
Insured's Address: _____

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: _____ Is insured a patient? __yes __no

Insured's Birth Date: _____ I.D #: _____ Group #: _____

Insured's 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: _____

_____

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that (or my dependants) have dental insurance coverage with _____ and assign directly to J.R. Pulido, DDS all 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 payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature: _____ Date: _____

Our Office and Financial Policies

Thank you for choosing us as dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

Appointments

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserve time. However, if you must change an appointment, a **24-hour notice** is expected. A fee may be applied for appointments missed without notice. Arrangement must be made in advance if a minor child (under age 18) is to seen without an adult present.

HEALTH HISTORY

Patient Name: _____ DOB _____ SSN _____

CIRCLE APPROPRIATE ANSWER

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If yes, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?
7. Yes No Are you taking any medicine(s) including non-prescription medicine? If yes, What are you taking _____
8. Yes No Have you ever taken Fosomax, Boniva, Actonel, or any cancer medications containing Bisphosphonates?
9. Yes No Do you use controlled substances?
10. Yes No Have you ever required a blood transfusion?

Physician's Name _____ Phone No. _____

Address _____

WOMEN ONLY

1. Yes No Are you pregnant or think you may be pregnant?
2. Yes No Are you taking birth control pills?

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

Local anesthetic like Novocain	Yes	No
Penicillin or other antibiotics	Yes	No
Barbiturates, Sedatives, or sleeping pills	Yes	No
Aspirin	Yes	No
Any metals (e.g., nickel, mercury, etc.)	Yes	No
Latex/Rubber	Yes	No

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

Rheumatic heart disease or Rheumatic fever	Yes	No
Scarlet fever	Yes	No
Heart defect	Yes	No
Heart trouble, heart attack, or angina	Yes	No
Chest pain	Yes	No
Shortness of breath	Yes	No
Pacemaker	Yes	No
Heart surgery	Yes	No
High/ low blood pressure	Yes	No
Congenital heart problem	Yes	No
Swelling of feet, ankle, hands	Yes	No
Hepatitis, jaundice or liver disease	Yes	No
Stroke	Yes	No
Sinus trouble	Yes	No
Lung or breathing problems	Yes	No
Asthma or hay fever	Yes	No
Hives or skin rash	Yes	No
Fainting or skin rash	Yes	No
Diabetes/Type I or II (circle one)	Yes	No
Aids or HIV infection	Yes	No
Thyroid problems	Yes	No
Allergies	Yes	No
Arthritis or rheumatism	Yes	No
Joint replacement or implant	Yes	No
Stent	Yes	No

Stomach ulcer	Yes	No
Kidney trouble	Yes	No
Tuberculosis	Yes	No
Persistent cough	Yes	No
Cough that produces blood	Yes	No
Chemotherapy (Cancer,Leukemia)	Yes	No
Sexually transmitted disease	Yes	No
Epilepsy or seizures	Yes	No
Anemia	Yes	No
Glaucoma	Yes	No
Nervousness	Yes	No
Tonsillitis	Yes	No
Tumors	Yes	No
Mental health care	Yes	No
Back problems	Yes	No
Chemical dependency	Yes	No
Mitral valve prolapse	Yes	No
Cortisone treatment	Yes	No
Cold sore/fever blisters	Yes	No
Hypoglycemia	Yes	No
Eating disorders	Yes	No
Rheumatoid arthritis	Yes	No
Systemic lupus erythematosus	Yes	No
Hemophilia	Yes	No

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 signature: _____ Date: _____

HEALTH HISTORY UPDATE

I have reviewed the attached health history. My health and medications have changed as follows (If no change, write "No Change").

Date: _____ Patient signature: _____ Staff signature: _____
Medical Change: Current medication:

Date: _____ Patient signature: _____Staff signature: _____
Medical Change: Current medication:

Date: _____ Patient signature: _____Staff signature: _____
Medical Change: Current medication: _____

Date: _____ Patient signature: _____Staff signature: _____
Medical Change: Current medication:

DENTAL HEALTH HISTORY

1. Are you having any discomfort at this time? Explain: _____
   _____
2. Have you ever had any serious complications associated with previous dental procedures? Explain: _____
3. Does dental treatment make you nervous? No __ Slightly __ Moderately __ Extremely __
4. Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
5. How often do you brush? _____Brush is: Soft ____ Medium ____ Hard ____
6. Do you have, or have you ever had any of the following? Please check those that apply:

Mouth	TEETH
__ Bleeding gums, sore gums	__ Loose teeth
___Unpleasant taste/bad breath	__ Sensitivity to heat
___ Burning tongue/lips	__ Sensitivity to cold
___ Frequent blisters, lips or mouth	__ Sensitivity to biting
___ Swelling/lumps in mouth	__ Food impaction
___ Braces	__ Clenching/grinding …
___ Biting of cheeks/lips	If so, when? _____
___ Clicking/popping jaw	__ Shifting in bite
___ Difficulty opening or closing	__ Change in bite

7. Are you happy with your smile and appearance of your teeth in general (color, shape, spaces)? _____ If “no”, why not? _____
   _____
8. Do you smoke? ___ Yes ___ No Do you use any other tobacco product? _____
   _____
   Frequency of use: _____
9. When was your last dental visit? _____ What was done then _____
   _____
10. How often did you visit the dentist before then? _____
11. Previous dentist (name, location and tel. #) _____
    _____
12. Have you had a complete series of dental x-rays taken when/where
    _____
13. How often do you brush? _____ floss? _____
14. Is your drinking water fluoridated? _____

HISTORIA MEDICA
HEALTH HISTORY

Nombre del paciente: _____No. de Seguro Social _____
Fecha de nacimiento _____

I. MARQUE CON UN CIRCULO LA RESPUESTA CORRECTA (Deje en blanco si no entienda la pregunta):

1. Si No Tiene Buena salud?
2. Si No Ha sufrido algun cambio en su salud el ultimo año?
3. Si No Ha estado hospitalizado o ha sufrido alguna enfermeded grave en los ultimos tres años? Por que? _____
4. Si No Se encuenta actualmento bajo tratamiento medico? Por que? _____
   Fecha de su ultimo examen medico: _____ Fecha de su ultima cita dental: _____
5. Si No Ha tenido problemas con algun tratamiento dental en el pasado?
6. Si No Siene dolor ahora?

II. HA NOTADO:

7. Si No Dolor de pecho (angina)?
8. Si No Los tobillos hinchados?
9. Si No Falta de aliento?
10. Si No Reciente perdida de peso, fiebre, sudor en la noche?
11. Si No Tos persistente o tos con sangre?
12. Si No Sangra facilmiente o excesivamente?
13. Si No Problemas de sinusitis?
14. Si No Dificultad al tragar?
15. Si No Diarrhea, estrenimiento, sangre en las heces?
16. Si No Vomitos con frecuencia, nauseas?
17. Si No Difficultad al orinar, sangre en la orina?
18. Si No Mareos?
19. Si No Ruidos en los oidos?
20. Si No Dolores de cabeza?
21. Si No Desmayos?
22. Si No. Vista borrosa?
23. Si No Convulsiones?
24. Si No Sed excesiva?
25. Si No Orina con frecuencia?
26. Si No Boca seca?
27. Si No lctericia?
28. Si No Dolor o rigidez en la articulaciones?

III. TIENE O HA TENIDO;

29. Si No Enfermedades del corazon?
30. Si No Infarto de corazone, defectos en el corazon?
31. Si No Soplos en el corazon?
32. Si No Flebre reumatica?
33. Si No Endurecimiento de las arterias?
34. Si No Presion sanguinea alta?
35. Si No Tuberculosis,enfisema, enfermedades del pulmon?
36. Si No Hepatitis, otras enfermedades del higado?
37. Si No Problemas delestomago, ulceras?
38. Si No Alergias a remedies, comidas, medicamentos?
39. Si No Familiares con diabetes, problemas de corazon?
40. Si No SIDA o ARC?
41. Si No Tumores, cancer?
42. Si No Artritis, reuma?
43. Si No Enfermedades de los ojos?
44. Si No Enfermedades de la piel?
45. Si No Anemia?
46. Si No Enfermedades venereas?
47. Si No Herpes?
48. Si No Entermedades del riñon, vejiga?
49. Si No Enfermedades de tiroides o de las suprarrenales?
50. Si No Diabetes?

IV. TIENE O HA TENIDO:

51. Si No Tratamiento psiquiatrico?
52. Si No Tratamientos de radiacion?
53. Si No Quimioterapia?
54. Si No Valvula artificial del corazon?
55. Si No Articulacion artificial?
56. Si No Hospitalizaciones?
57. Si No Transfusiones de sangre?
58. Si No Cirugias?
59. Si No Marcapasos?
60. Si No Lentes de contacto?

V. ESTA TOMANDO:

61. Si No Drogras de uso recreativo?
62. Si No Medicamentos, incluyendo aspirina?
63. Si No Tabaco de cualquier tipo?
64. Si No Alcohol?

Por favor haga una lista: _____

VI. SOLO PARA MUJERES:

65. Si No Esta o podria estar embarazada o dando pecho? 66. Si No Esta tomando pastillas anticonceptivas?

VI. PARA TODOS LOS PACIENTES:

67. Si No Tiene o ha tenido alguna otra enfermedad o problema medico que no este cuestionerio?
Si la respuesta es afirmativa, explique: _____
_____

Firma del paciente _____Fecha _____

REVISION SUPLEMENTARIA:

1. Firma del paciente _____Fecha _____
2. Firma del paciente _____Fecha _____
3. Firma del paciente _____Fecha _____
4. Firma del paciente _____Fecha _____

Insurance
As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, **we do require you to pay your deductible and/or "estimated portion" at the time of service.** The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form if needed. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of Basic procedures and 50% of Major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits. _____
Initial

Usual and Customary Rates
Please be aware that some of our services maybe "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. **You are responsible for any balance left unpaid by your insurance company.** The adult accompanying a minor is responsible for full payment.

Payment Options and Account Information
In order to maintain our fees at a reasonable level, we do not send monthly statements. If a balance is over 30 days, a billing fee will be charged at the rate of 1.5% per month of the total balance, or $10.00, whichever is greater. In the event we receive a returned check for insufficient funds or a closed account, there will be a $35.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.
Thank you for understanding our guidelines. Please let us know if you have any questions or concerns.
I have read, understand, and agree to the above office and financial policies.

X_____ _____
Signature of patient or responsible party Date