

J. R. Pulido, DDS

Patient Information

Patient Name: _____ Date: _____

Last
First
M I
Preferred name

 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: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Mitro Valve Prolaspe |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

Please list any medications you are currently taking _____

- Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____
- Are you now under the care of a physician? Yes No
 If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper 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 of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

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: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

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 I (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 _____

Dental Health Information

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 ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____
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 <ul style="list-style-type: none"><input type="checkbox"/> Bleeding, sore gums<input type="checkbox"/> Unpleasant taste/bad breath<input type="checkbox"/> Burning tongue/lips<input type="checkbox"/> Frequent blisters, lips or mouth<input type="checkbox"/> Swelling/lumps in mouth<input type="checkbox"/> Braces<input type="checkbox"/> Biting of cheeks/lips<input type="checkbox"/> Clicking/popping jaw<input type="checkbox"/> Difficulty opening or closing jaw	TEETH <ul style="list-style-type: none"><input type="checkbox"/> Loose teeth<input type="checkbox"/> Sensitivity to heat<input type="checkbox"/> Sensitivity to cold<input type="checkbox"/> Sensitivity to sweets<input type="checkbox"/> Sensitivity to biting<input type="checkbox"/> Food impaction<input type="checkbox"/> Clenching/grinding ... If so, when? _____<input type="checkbox"/> Shifting in bite<input type="checkbox"/> Change in bite
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7. Are you happy with your smile and the 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: _____

For Completion by Dentist Only

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

management considerations:

(Date)

(Signature of Dentist)

MEDICAL HISTORY UPDATE:

<u>Date</u>	<u>Comments</u>	<u>Signature</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Our Office and Financial Policies

Thank you for choosing us as your 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 reserved time. However, if you must change an appointment, a **24-hour notice** is expected. A fee may be applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

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 patient 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 may be "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 \$7.00, 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