Welcome!

We are honored that you have chosen us as your new dental health team. We look forward to working with you in maintaining your oral health! Please fill out the following forms & return to the front desk when complete. Thank you!

Name (First, MI, Last): _____

Preferred Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Please Circle: (Male) (Female) (Married) (Single)

Email:_____SSN: _____

Patient Employer:_____

Other family members in our office: _____

You were referred to us by: _____

Emergency Contact

Name: _____ Relationship: _____ Ph #_____

Person financially responsible for account

Name: _____ Relationship to Patient: _____

Address: _____Ph #: _____

Dental Insurance Primary Insurance Company:_____

Policy Holder Name: _____

DOB: _____Relationship to Patient: _____ SSN or ID:_____

Employer: _____

Dental Insurance Secondary Insurance Company:_____

Policy Holder Name: _____

DOB: _____ Relationship to Patient: _____SSN or ID #: _____

Employer: _____

Patient/ Guardian Signature: _____ _ **Date:** _____

Montoya Family Dental

MED ALERT

Patient Name _____

Address _____

City/State _____

Phone _____

Email_____ Weight:_____ Height:_____ DOB: _____

Employer_____

Primary Physician _____ Physician Phone _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response. Leaving it blank will indicate a "NO" response.

- Heart Attack
- Heart Surgery
- Heart Disease
- Chest Pain
- Congenital Heart Disease
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Mitral Valve Prolapse
- Artificial Heart, Valve/Pacemaker
- Rheumatic Fever
- Arthritis/Rheumatism
- Cortisone Medicine
- Swollen Ankles
- Stroke (When_____)
- Diet (Special/Restricted)
- Artificial Joints (When_____ Type_____)
- Ulcers
- Diabetes
- Thyroid Problems
- Glaucoma
- Contact Lenses
- Emphysema
- Sickle Cell Disease
- Bruise Easily
- Nervous/Anxious
- Psychiatric/Psychological Care
- Cancer (When____Type_____)
- Radiation Therapy
- Chemotherapy (When_____)
- Chronic Cough
- Tuberculosis
- Asthma
- Hay Fever/Allergies/Hives
- Latex Sensitivity
- Sinus Trouble
- Tumors (Type_____)
- Hepatitis A B C (circle)
- Venereal Disease
- A.I.D.S/H.I.V Positive
- Cold Sores/Fever Blisters
- Blood Transfusion
- Hemophilia
- Liver Disease
- Fainting/Dizzy Spells
- Birth Control
- Are you **currently** Pregnant or Nursing? (circle)
- Kidney Trouble
- Recent Surgery_____
- **Other** (If yes please list)_____
- Currently taking any **medications** (if yes please list):

  _____
- Have you ever been told to take a **premedication** prior to dental treatment?

If yes, please describe: _____

- ☐ Taken **bone loss prevention drug** such as: Fosamax, Actonel, Boniva, or other bisphosphonates
- ☐ **Allergic** (or adverse) reaction to any substance or medication (if yes please specify):

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Montoya Family Dental

Office Policies

Our Hours: Tuesday–Thursday 8am–5pm, and on select Mondays & Fridays 8am–1pm.

Contact us: Phone: (805) 466-6713

Financial Policy: Payment is required at time of service. We accept Cash, Check, Visa, MasterCard, Discover, American Express, Care Credit, and Cherry. We accept pre-payment for all dental treatment. A $25 fee will apply to all returned checks.

Insurance: Patients who carry dental insurance understand that billing of dental insurance is a courtesy we provide to our patients free of charge. We are not legally obligated to provide this service. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office tries to be familiar with, but may not be fully aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid.

Cancellation/No-Show Policy: We realize your time is valuable and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice or who fail to keep their scheduled appointments. In order to be respectful of the needs of all Montoya and Kang Dental patients, if it is necessary to cancel your reserved appointment we require that you contact our office **48 hours prior to your appointment**. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care.

A ‘no-show’ appointment occurs when a patient no-shows to an appointment. No-shows inconvenience patients who need access to dental care in a timely manner.

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a ‘no show’ or Last Minute Cancellation. The **first two ‘no show’ or last minute cancellations will result in a $75 fee being applied to your account**. **A valid credit or debit card must be kept on file, and any applicable no-show fees may be charged to that card.** A third ‘no show’ or last minute cancellation will result in suspension of services and dismissal from our dental practice. Exceptions to this policy must be approved by the doctor.

Medical Debt Disclosure: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Name: _____

Signature: _____

Date: _____

Revised October 23, 2025

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I can obtain a copy of the notice, explaining how my medical information will be used and disclosed, upon request. I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Print Patient Name _____

Signature _____ Date _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____ If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/___/____