DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Financial Policy Agreement

Welcome to Willow Glen Family Dentistry! We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. Providing complete comprehensive dental services includes discussing all treatment and financial options available to you.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Apple Pay, and most credit cards. Payment plans and financial arrangements are available. Emergency patients new to our practice should expect to make a payment in full at the time of service.

INSURED PATIENTS: Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance information and all your required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. Should any problems arise, you will need to contact them directly.

We are required by your insurance to collect any deductible or estimated co-payment amount that will be due at the time of treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you. Failure to do so may result in dismissal from the practice.

USUAL AND CUSTOMARY RATES: Our practice is committed to proving the most up to date and highest quality dental care. We charge what is usual and customary in our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we do our best to estimate what your particular insurance plan will pay as each plan has specific limitations and exclusions.

DENIED/UNPAID CLAIMS: If a claim for treatment has been denied either before or after treatment is completed, it is your responsibility to pay in full. As a courtesy, we can resubmit a claim up to one time if needed.

BILLING: For all accounts over 60 days past due, there will be a finance charge of 5% per month (to you) until account is paid regardless of insurance delays. We assign all accounts over 120 days to our collection agency for processing unless payment arrangements have been made. Should your account become past due, you agree to pay any and all reasonable fees, including collection agency fees, legal fees, and/or court costs necessary to collect this account.
Lastly, appointments are reserved exclusively for you. If an appointment is not cancelled at least 48 hours in advance, or if you fail to keep your appointment, you will be charged a fifty-dollar ($50) fee. This fee will not be covered by your insurance company.

Should you have any questions about your financial obligation prior to treatment, please call the office at (408) 266-6811.

I have read and understand this financial policy.

_____	_____	_____
Printed Name	Signature	Date

NOTICE OF PRIVACY PRACTICES

This is to inform you about the legal requirements mandated by HIPAA (Health Insurance Portability and Accountability Act) that allows Health Care Providers to provide services to patients as long as the practice (Willow Glen Family Dentistry) takes reasonable and appropriate measures to protect patient privacy.

The Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form are kept properly confidential. This Act gives you significant rights to understand and control how your health information is used.

_____I have been given the opportunity to review the HEALTH INSURANCE PORTABILITY ACT (HIPAA).

(initial)

_____I have been given the opportunity to review the DENTAL MATERIAL FACT SHEET (DMFS).

(initial)

_____I have been given the opportunity to review Willow Glen Family Dentistry's NOTICE OF PRIVACY
(initial)

PRACTICES.

_____Upon my request I will be provided with a copy of this material.

(initial)

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.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Patient Name : _____

TREATMENT TO BE DONE · I understand and consent to have any treatment done by the dentist after the procedure, the risk and benefits and costs have been fully explained. These treatments include, but are not limited to, x-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, and/or dentures. (Initial _____)

PERIODONTAL DISEASE · I understand that periodontal diseases is a serious condition causing gums and bone inflammation and /or loss and that it can lead to the loss of my teeth. I understand the alternative treatment plans to correct periodontal disease, including gum surgery tooth extractions with or without replacement. I understand the undertaking any dental procedures may have future adverse effect on my periodontal condition. (Initial _____)

FILLINGS · I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage I understand that a more extensive filling or a crown may be required, as additional decay or fracture may become evident after initial excavation. I understand that significant sensitivity is a common, but usually temporary, after effect of a newly placed filling. I further understand that filling a tooth may irritate the nerve tissue creating sensitivity and treating such sensitivity could require root canal therapy. (Initial _____)

CROWNS (CAPS) AND BRIDGES · Preparing a tooth may irritate the nerve tissue in the center of the tooth, leaving your tooth feeling sensitive to heat, cold and pressure. Treating such irritation may involve using special toothpaste's or mouth rinses or root canal therapy . I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is my responsibility to return for permanent cementation within 20 days from tooth preparation, as excessive delays may allow for tooth movement, which may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation, and I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before permanent cementation.
(Initial _____)

ENDODONTICS TREATMENT (ROOT CANAL) · I understand there is no guarantee that root canal treatment will save a tooth, and that complications can occur from the treatment, and that occasionally root canal filling materials may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and drills are very fine instruments and stresses vented in their manufacture and calcifications present in teeth can cause them to break during use. I understand that referral to an endodontist for additional treatments may be necessary following any root canal treatment , and I agree that I am responsible for any additional costs for treatment performed by the endodontist. I understand that a tooth may require extraction in spite of all efforts to save it. (Initial _____)

REMOVAL OF TEETH · I understand that alternatives to tooth removal (root canal therapy, crowns, and periodontal surgery, etc.) and I agree to completely understand these alternatives, including their risk and benefits prior to authorizing the Dentist to remove teeth and any others necessary for reasons as above I understand that removing teeth does not always remove all the infections, if present and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by specialist if complications arise during or following treatment, the cost of which is my responsibility. (Initial _____)

DENTURES · I understand that wearing of dentures can be difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. A permanent reline will be needed later, which is not included fee. I understand that all adjustments are included in the denture fee for a period of six months from the date of delivery, and that any and all adjustments or alterations of any kind after this initial period are subject to charges.
I understand that dentistry is not an exact science and that no dentist can properly guarantee results. (Initial _____)

DRUGS AND MEDICATIONS · I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting, and or anaphylactic shock (Initial _____)

CHANGES IN TREATMENT PLAN · I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that was not discovered during examination. For example, root canal therapy is following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.
(Initial _____)

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is subject to modification depending on undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have. I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fee, or court costs that may be incurred to satisfy any obligation to this office

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Doctor Signature Date

INFORMED CONSENT