



**Patient Information**

Name: \_\_\_\_\_  
Last First Middle  
E-Mail Address: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_ Identify \_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street City State Zip  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's License or ID Number: \_\_\_\_\_  
MM / DD / YYYY

**Responsible Party Information (If Patient is a Dependent)**

Name: \_\_\_\_\_  
Last First Middle  
Relationship to Patient: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street City State Zip  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number: ----- Driver's License or ID Number: \_\_\_\_\_  
MM / DD / YYYY

**Dental Insurance Information (Please Provide a Copy of Your Card)**

Name of Primary Policy Holder: \_\_\_\_\_  
Last First Middle  
Primary Policy Holder's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Primary Policy Holder's SS/ Member ID Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
MM / DD / YYYY  
Primary Policy Holder's Employer: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Insurance Company Phone: (\_\_\_\_) \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Street City State Zip

**Emergency Contact Information**

Local Friend or Relative: \_\_\_\_\_ Emergency Contact Phone: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact Address: \_\_\_\_\_  
Street City State Zip

**Getting to Know You**

Why did you select our office? \_\_\_\_\_ Whom May we thank for referring you? \_\_\_\_\_  
Is another member of your family already a patient with our practice?  Yes  No Family Member? \_\_\_\_\_  
When was your last dental visit? \_\_\_\_\_  
When was the last time you had complete dental x-rays taken? \_\_\_\_\_ Have you ever had any teeth removed? \_\_\_\_\_  
How long have these teeth been missing? \_\_\_\_\_  
How Have these teeth been replaced?  Bridge  Partial  Denture  Implants  They have not been replaced

**FOR ALL PATIENTS**

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

\_\_\_\_\_  
TO PATIENT SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

**MEDICAL HISTORY – Please Answer ALL Questions**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Primary Care Physician: \_\_\_\_\_ Phone/Contact: \_\_\_\_\_

1. Do you consider yourself a healthy person? .....  Yes  No

2. Would you like a comprehensive oral cancer exam? .....  Yes  No

3. Have you been under the care of a medical doctor during the past two years? .....  Yes  No

If yes, for what reason? \_\_\_\_\_ Est. Last Physical Exam Date: \_\_\_\_\_

4. Do you consider your teeth, gums and mouth to be healthy and problem free? .....  Yes  No

5. Do your gums bleed at any time? .....  Yes  No

6. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? .....  Yes  No

If yes, please list. \_\_\_\_\_

7. Have you ever had excessive bleeding requiring special treatment? .....  Yes  No

8. Women: Are you or might you be pregnant? .....  Yes  No Estimated Due Date \_\_\_\_\_

9. Check any and all of the following which you have a history of or currently under treatment for:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Ulcers                             | <input type="checkbox"/> HIV Positive (AIDS)          |
| <input type="checkbox"/> Tuberculosis (TB)       | <input type="checkbox"/> Shortness of Breath                | <input type="checkbox"/> Cancer or Tumor              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hepatitis (circle: Type A, B or C) | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Liver Disease                      | <input type="checkbox"/> Heart Murmur/Mitral Valve    |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Bruise Easily                |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Thyroid Disease                    | <input type="checkbox"/> Drug Addiction               |
| <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia)    | <input type="checkbox"/> Hemophilia                   |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Artificial Joint        | <input type="checkbox"/> Cortisone Medication               | <input type="checkbox"/> Epilepsy or Seizures         |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Nervousness                  |
| <input type="checkbox"/> Kidney Trouble          | <input type="checkbox"/> Pain in Jaw Joints                 | <input type="checkbox"/> Psychiatric Treatment        |

Do you have or have history of any surgery, disease or medical condition not listed on this form? .....  Yes  No

Please list: \_\_\_\_\_

10. List all Prescription Medications you are taking at this time.  None \_\_\_\_\_

11. Do you use any type of tobacco product regularly? .....  Yes  No

12. Do you use or have you ever used recreational drugs? .....  Yes  No

13. Do you clench or grind your teeth? .....  Yes  No

14. Do you or have you been told you snore loudly (enough to bother others)? .....  Yes  No

15. Are you aware or have you been told you stop breathing or are choking while sleeping? .....  Yes  No

16. Do you often feel tired, fatigued or can't stay awake during the daytime? .....  Yes  No

17. Do you currently use or have been diagnosed to need a CPAP breathing machine to sleep? .....  Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

**Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can be of service to you as comfortable as possible.**

1. Please rate the following statements regarding what is most important to you in dental care so we can best serve you: (#1 being the most important)

\_\_\_ Long-Term Preventative Care...I have healthy teeth and want to keep them that way.

\_\_\_ Creating a Comprehensive Overall Dental Care Plan...I want to Invest in my Teeth and Appearance

\_\_\_ Dental Care is budget driven. I will have to plan financially for any treatment beyond my immediate needs.

\_\_\_ Other Goals: \_\_\_\_\_

2. Please circle how important is it for you to keep your teeth for a lifetime? (10 being very important)

1    2    3    4    5    6    7    8    9    10

3. Are you concerned about: (please circle yes or no)

Replacing missing teeth                      Yes    No                      Straightness of your teeth or bite                      Yes    No

Eliminating any cavities                      Yes    No                      Snoring at night                      Yes    No

Gum disease                      Yes    No                      Color of your teeth                      Yes    No

Bad breath                      Yes    No                      Appearance of your smile                      Yes    No

4. Are you or anyone in your family interested in a **complimentary** orthodontic (Braces or Invisalign) consultation with our Orthodontist?                      Yes    No

**We know dental care can be very stressful for most people. Please share your concerns and past experiences to help guide us in serving you and your family more effectively.**

5. Please circle the level of fear you have regarding dental treatment for yourself. (10 being the most fearful, 1 being the least amount of fear)

1    2    3    4    5    6    7    8    9    10

6. When we review your treatment plan with you, would you like to know (please check one):

\_\_\_ I am a big picture type person, I prefer to review the plan looking at all the things that need to be done.

\_\_\_ I am a detail-oriented person, I prefer to approach each treatment step along the way

7. Please briefly describe any bad dental experiences you have had: \_\_\_\_\_

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**THANK YOU**

DENTAL INSURANCE POLICY

Alameda Dental proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service. Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.** I understand that I am responsible for all costs of collection including attorney fees. Collection fees of 30% and court costs. I understand that an unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me via e-mail, text messaging and to cellular devices.

-----**PATIENT ACKNOWLEDGMENT AND AUTHORIZATION**-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Alameda Dental. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

APPOINTMENT DEPOSIT REQUIREMENT

**Alameda Dental requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$500 or more.** The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Alameda Dental requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject to our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

Saturday appointments require a \$25 deposit because our providers and dental assistants reserve the appointment time specifically for you. The deposit operates as a credit on the account to secure future Saturday appointments. **The deposit requirement is subject to our Cancellation Policy.**

I understand and agree.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CANCELLATION POLICY

Alameda Dental makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours' notice if you are unable to keep your scheduled appointment. We reserve the right to charge a cancellation fee of \$50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, \_\_\_\_\_, have had the opportunity to review Alameda Dental's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed out notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected heal information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we hall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allow for the use of the information of treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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This consent was signed by: \_\_\_\_\_

(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_