

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

test: _____

test2: _____

test3: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Patient Name: _____

Birth Date: _____

Date Created: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date: _____

**David Family Dentistry
Vicente David, Jr., DMD
148 Best Avenue
San Leandro CA 94577**

Consent for Use and Disclosure of Health Information

Section A – Patient Giving Consent

Name - _____ DOB - _____

Address - _____

Telephone - _____

Section B – Please Read The Following Statements Carefully

Purpose of Consent – 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.

Notice of Privacy Practices – You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. The changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting –

David Family Dentistry – (510) 569-1740 – vdavid@sanleandrodentist.com

Right To Revoke – You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will affect any action we took in reliance on this Consent before we received your revocation, and that we may no longer be able to treat you if you revoke this Consent.

Section C - Signature

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices and I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature - _____ Date - _____

DAVID FAMILY DENTISTRY

148 Best Avenue

San Leandro, CA 94577

Telephone (510) 569-1740

Thank you for choosing our practice! As we promise to do our best to assist you in the best way we can with your dental needs, we would like to describe how financial responsibilities are delegated and fulfilled in our office. Please read the following policies and initial to ensure that you read, understand and will comply with our financial policies.

At David Family Dentistry, we believe that you deserve the best care. That’s why we always present you with the best dental solution possible to treat your personal situation. Each year we provide dental care to numerous patients. Some have dental benefits, but some do not. If you have dental insurance here are some things you should know:

- 1. **As a courtesy to you, our patient, while we do accept assignment of benefits, it is your responsibility to know your insurance coverage and benefits including co-pay, deductible, and coinsurance. If you have any questions about what services may be covered by insurance, please contact your insurance company prior to your appointment.**
- 2. **It is your responsibility to keep our office updated when insurance is updated yearly or changed so we always have current proof of insurance on file.** X_____
- 3. **We bill your insurance company directly; however; if your insurance company for whatever reason, does not cover the charge, the balance will automatically be billed to you.** X_____
- 4. **Missed Appointments and Cancellations:** As a courtesy, our office sends out phone/email/text reminders prior to your appointment date. To cancel or request a change to an existing appointment, you have the option of calling, emailing, or sending us a message via text prior to your appointment. **Should there be a no show or late cancellation, without 24-hour notice, an additional charge of \$25 will be billed to your account.** X_____

We bill your insurance as a courtesy. If your insurance does not pay within 90 days, David Family Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is very rare but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

David Family Dentistry does require payment in full for your portion at the time of service. We accept Visa, MasterCard, and Discover, cash and check (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, who offers six months “same as cash” or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

Account Balance: We charge a 2% per month interest on account balances over 60 days. X_____

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you’ve always wanted. If there is anything we can do to make your visits here more pleasant, please do not hesitate to tell us.

Print: _____ Date: _____

Signature: _____