

# Welcome to Dublin Ranch Dental

## Patient information

Name \_\_\_\_\_ E-Mail: \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_\_\_ Home Ph # \_\_\_\_\_ Work/cell # \_\_\_\_\_

Address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Sex: M / F Family status: \_\_\_\_\_ Emergency contact name and ph# \_\_\_\_\_

## Responsible party

Responsible person for account \_\_\_\_\_ Relation to patient \_\_\_\_\_

SS# \_\_\_\_\_ Phone# \_\_\_\_\_ Driver license# \_\_\_\_\_

## Health history

Family physician: \_\_\_\_\_ Ph# \_\_\_\_\_

Are you currently taking any medications? YES NO  
If so for what? \_\_\_\_\_

Have you been under care by a physician during the last two years and for what? YES NO  
If so for what? \_\_\_\_\_

## Check if you have or had any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Heart problems                               | <input type="checkbox"/> Fen-phen                      |
| <input type="checkbox"/> Heart murmur                                 | <input type="checkbox"/> Kidney disease/transplants    |
| <input type="checkbox"/> Mitral valve prolapse                        | <input type="checkbox"/> Cancer/radiation/chemotherapy |
| <input type="checkbox"/> Artificial heart valves/joints, implants etc | <input type="checkbox"/> Asthma/lung disease           |
| <input type="checkbox"/> Rheumatic fever                              | <input type="checkbox"/> Epilepsy/psychiatric problems |
| <input type="checkbox"/> Pacemaker                                    | <input type="checkbox"/> Latex allergy                 |
| <input type="checkbox"/> Stroke                                       | <input type="checkbox"/> Smoke                         |
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Sexually transmitted disease  |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Pregnant                      |
| <input type="checkbox"/> Liver disease/hepatitis                      | <input type="checkbox"/> Nursing                       |
| <input type="checkbox"/> Aids/HIV                                     | <input type="checkbox"/> Other conditions              |
| <input type="checkbox"/> Bleeding disorders                           |  |

Do you have any allergies to any medications: \_\_\_\_\_ YES NO  
If so what? \_\_\_\_\_

Do you have or had any disease or condition not listed above? YES NO  
If so, what? \_\_\_\_\_

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have change in health. Should further information be needed, you have my permission to request my health care provider to release the information to you.*

**Patient/parent/Legal guardian signature**

**Date**

Recall Signature

Date

Recall Signature

Date

Recall Signature

Date

Recall Signature

Date

# Welcome to Dublin Ranch Dental

## Dental history

Reason for leaving last dentist \_\_\_\_\_

Reason for today's visit \_\_\_\_\_ Date of last dental care? \_\_\_\_\_

**Our office is like no other dental office.** This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. You probably never thought of these issues. Please check what best expresses how you feel about the following questions:

Tell us in your opinion, what you think the present state of the health of your mouth is? \_\_\_\_\_

How do you feel about the appearance of your face and smile? \_\_\_\_\_

What do you already know about our office and what are your expectations?  
\_\_\_\_\_

What kind of a good dental experience would develop the trust for us to be your dentist?  
\_\_\_\_\_

Has the cost of dental treatment been concern for you, and how can we help there? \_\_\_\_\_

**Check  if you have any of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Bad breath                     | <input type="checkbox"/> Clenching/Grinding        |
| <input type="checkbox"/> Bleeding gums                  | <input type="checkbox"/> Jaw pain/popping/clicking |
| <input type="checkbox"/> Sensitive teeth                | <input type="checkbox"/> Loose teeth               |
| <input type="checkbox"/> Broken fillings/food impaction |  |

How often do you brush and floss? \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ ID # \_\_\_\_\_ DOB \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

**Patient 's relationship to insured:**  Self  Spouse  Child  Other

#### Secondary

Name of Insured: \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_

Inusred's Employer Name: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

**Patient 's relationship to insured:**  Self  Spouse  Child  Other

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby consent my dentist to take any necessary X-rays, models, and photographs and perform a thorough diagnosis and treatment as needed. I also consent my dentist to perform all recommended treatment mutually agreed upon by us, and use of appropriate medication and therapy indicated for such treatment.*

\_\_\_\_\_  
**Patient/parent/guardian signature**

\_\_\_\_\_  
**Date**

## CONSENT FOR SERVICES & OFFICE POLICIES

### Financial and Insurance Policies:

It is our objective to provide our patients with the latest dental technology, superior dental materials and excellent care in a modern comfortable environment. In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between you and your dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between you and your dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.

I give my approval and consent to start my dental treatment. To the best of my knowledge, I am currently eligible for dental treatment through my insurance company. I have reviewed the treatment plan and fees and hereby assume complete financial responsibility for services rendered that are not paid for by my insurance company.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

*Any account balance which is not on the payment plan and which is over 60 days old will have finance charges of 1.5% (18% percent per month (18% APR) added. In the event that an account becomes past due over 90 days, it may be given to an outside collection agency, unless previously written financial arrangements are satisfied.*

### Office Cancellation Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee of \$50/per hour applies for broken appointment.

**I have read the above conditions of payment and agree to their content.**

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

\_\_\_\_\_  
**Signature of patient, parent or legal guardian**

### HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) took effect on April 14, 2003. This federal law requires our office to provide a notice of privacy practices. This policy is posted in the reception area entitled "Notice of Privacy Practices." You may also request a paper copy. We would appreciate you taking the time to sign the bottom of this form certifying you have received this office's Notice of Privacy Practices.

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**Signature** for acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES

### Proposition 65:

The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTALMATERIALS FACT SHEET". It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document please feel free to bring your questions to our attention.

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**Signature** for receipt of DENTAL MATERIALS FACT SHEET