TIME 4:14 PM DATE 8/17/2010

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☑ Responsible Party Preferred Name:

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: Elk Grove State / Zip: CA 95624 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: Andrea Cervantes, D.D.S.

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.: Andrea Cervantes, D.D.S.

Section 3

Referred By:

Previous Dentist:

Emergency Contact:

Emergency Contact #:

Physician name:

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

MEDICAL HISTORY

FOR

Birth Date:

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, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

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 _____ DATE _____

SHELDON GROVE
FAMILY DENTAL

EMERGENCY CONTACT

Name: _____
Relationship: _____
Home #: _____ Work#: _____
Mobile #: _____

MEDICAL HISTORY

Do you have a personal physician?
☐ Yes ☐ No
Physicians name: _____
Phone #: _____
Date of last visit: _____
Preferred Hospital: _____

Please share the following approximate dates:

Your last cleaning: _____
Your last complete x-rays: _____

Are you nervous about coming to the dentist?

☐ A lot ☐ A little ☐ Not at all

How did you hear about us?

☐ Phone Book ☐ Internet ☐ Friend/Relative
☐ Mailer ☐ Sign ☐ Other: _____

If you could change your smile, would you:
(Please check all the apply)

☐ Make your teeth whiter
☐ Make your teeth straighter
☐ Close spaces between teeth
☐ Replace black metal fillings with tooth-colored restorations
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Replace old crowns that don't match

Please check any of the following problems that apply to you:

☐ Sensitivity (hot, cold, or sweet)
If so, which teeth _____
☐ Headaches, earaches, neck pain
☐ Teeth or fillings breaking
☐ Difficulty opening, closing or chewing
☐ Grinding or clenching teeth
☐ Bleeding, swollen, or irritated gums
☐ Loose, tipped, or shifting teeth
☐ Bad breath

What is the most important objective for your dental visit?

_____

_____

DISCLAIMER, AUTHORIZATION & RELEASE

I authorize Dr. Cervantes to release information including diagnosis and records of any treatment or exam rendered to me or my child during the period of dental care to third party payers and health practitioners. I authorize and request my insurance company to pay directly to Dr. Cervantes benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that I may be charged interest on balances over 60 days old. I further authorize Dr. Cervantes to run credit checks as necessary when providing credit.

_____

Signature (Of patient or parent if minor) Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

SHELDON GROVE
FAMILY DENTAL

Sheldon Grove Family Dental-Office Policies

Financial Policy: It is our policy to receive the patient's portion of payment in full at time of service. Our office works directly with the insurance company and will bill them as a courtesy to you. For your convenience, we accept cash, personal checks, money orders, and credit card payments at the time of service. The practice also as an arrangement with CareCredit that may also fit your needs.

If you carry a balance in our office that is over 90 days old your account will be charged a 2% finance charge (compounded monthly) until balances are paid in full, unless other arrangements have been made with the office manager.

Insurance: We will file all dental claims for you on your behalf as a courtesy, but the patient is ultimately responsible for all charges. We will submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee an estimated coverage. Please read your policy thoroughly to be aware of the benefits provided and the limitations imposed. You should be aware that all insurance companies differ in the types of coverage available. Some companies process claims promptly, while other delay payments for months. Since SGFD is not a party to the agreement you have with your insurance company, you will be held accountable for all charges. If you insurance company has not paid their portion within a reasonable amount of time (generally ninety days), you will be asked to take care of any outstanding balance.

Estimates: We will give you an estimate for your portion based on the information given to us by your insurance carrier. Please remember that this is only an estimate. We will provide you with written treatment plans at all appointments where needed. A treatment plan estimate include our fee, the estimated insurance benefit, and what your patient portion amount. Treatment plans may change depending on the patient needs. We will always do our best to keep you informed of any changes.

Broken Appointments: There is a $50 penalty fee for broken or failed appointments less than 48 hours notice. We understand that life can be very busy and is filled with unforeseen circumstances. However, should you need to need to reschedule an appointment, please inform us within 48 hours of your appointment. Two or more missed appointments without notification may result in dismissal from the practice.

I have received the office policies and have been given the opportunity to ask questions to clarity any policy I did not understand.

_____ _____

Patient/Parent Signature Date