

## Confidential Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)  
Gender: \_\_\_\_\_ Family Status:  Married  Single  Divorced  Child  Other \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_ Email: \_\_\_\_\_  
Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell/Pager): \_\_\_\_\_  
Best time to call: \_\_\_\_\_ **Whom may we thank for referring you to our practice?** \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Street City State Zip Code  
Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S  
Would you like to be on our short-call list?  Yes  No. If yes, how fast can you be here? \_\_\_\_\_  
Employer/School Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer/School Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Code  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact's Address: \_\_\_\_\_  
Street City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_  
What would you like to discuss with the dentist today: \_\_\_\_\_  
Are you pleased with your smile?  Yes  No. If no, why not: \_\_\_\_\_  
Mark on the scale from 1 to 10 where you would place the value of keeping your teeth and oral health in optimum condition?  
1 2 3 4 5 6 7 8 9 10 Former Dentist Name: \_\_\_\_\_  
**Have you ever had any of the following? Please check those that apply:**  

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Attack/Angina	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Disease	Due date: _____	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> TMJ (Jaw click, etc)
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	OTHER:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> _____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Sinus Problems	_____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Problems	_____

• Are you taking prescribed or any over the counter medication? Birth Control Medications?  Yes  No  
If yes, list medications: \_\_\_\_\_

• Are you allergic to any medications?  Yes  No  
If yes, list medications: \_\_\_\_\_

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past five years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name and Address of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Code

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

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

Signature of patient, parent or guardian

## Guarantor or Payment Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  self (if self, please provide the closest relative's information)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Male  Female  Married  Single  Divorced  Separated  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_ Email: \_\_\_\_\_

Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell/Pager): \_\_\_\_\_

Address: \_\_\_\_\_ How long at this address: \_\_\_\_\_

\_\_\_\_\_  
Street City State Zip Code  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Street City State Zip Code

## Insurance Information

**Primary (Please provide office staff a copy of your dental insurance card)**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

\_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

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

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Plan Name, Address and Phone #: \_\_\_\_\_

**Secondary (only if you have dual dental coverage)**

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

\_\_\_\_\_  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

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

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Plan Name, Address and Phone #: \_\_\_\_\_

## Consent for Services

\_\_\_\_\_ I hereby authorize Santa Teresa Dental and its doctor & staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Dr. Huang to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

\_\_\_\_\_ I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefit directly to Santa Teresa Dental, otherwise payable to me. We will gladly bill your insurance company for you. However, if we do not receive payment from them within 35 days you will be responsible at that time for the entire bill. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment or estimated patient portion (for patient with dental insurance) is due at the time of service unless other arrangements have been made. In the event payments are not received at agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

\_\_\_\_\_ I grant my permission to Santa Teresa Dental, to telephone me at home or at my work to discuss matters related to this form.

\_\_\_\_\_ I understand that where appropriate, credit bureau reports may be obtained.

\_\_\_\_\_ Cancellation policy has been explained to me. I understand that Santa Teresa Dental reserves the right to charge \$50 for appointments not cancelled within 48 hours.

\_\_\_\_\_ I understand that it is my responsibility to advise Santa Teresa Dental of any changes in the information obtained in this form.

\_\_\_\_\_ I have received a copy of Santa Teresa Dental's Notice of Privacy Practices for me (or my child's). It is OK to discuss my child's and/or my treatment with \_\_\_\_\_ all immediate family, \_\_\_ all family members \_\_\_ other (please elaborate) \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of patient, parent or guardian

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party