MAIN STREET
PEDIATRIC DENTISTRY & ORTHODONTICS

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PEDIATRIC DENTISTRY & ORTHO
Proudly Serving the Bay Area for over 28 years

ABOUT YOU

Today's Date: _____
Email Address: _____
Name: _____
I prefer to be called: _____ _____
Birth date: ____/____/____ Age: _____
SS#: _____
Home address: _____
City: _____ St. _____ Zip _____
Home Phone#: _____
Cell/Other#: _____
Work Phone#:(____) _____ Ext: _____
Driver's License#: _____

Marital Status:
❑ Single ❑ Married ❑ Partnered
❑ Divorce/Separated ❑ Widowed

Employer: _____
Occupation: _____
When and where are best times to reach you? _____
_____
Whom May we thank for referring you? _____
Others Family members seen by us? _____
Optional Info to help the doctor get to know you:
Your Special Interest/Hobbies: _____
How long have you lived in area? _____

SPOUSE INFORMATION

His/Her Name: _____
Employer: _____
Work Phone#:(____) _____ Ext: _____
SS#: _____
Birth date: ____/____/____ Age: _____
Driver's License#: _____

PRIMARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#:(____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/____/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

SECONDARY INSURANCE

Dental Coverage ❑ Yes ❑ No
Insurance Co Name: _____
Insurance Co. Address: _____
City: _____ St. _____ Zip _____
Insurance Co. Phone#:(____) _____
Group #(Plan, Local, or Policy): _____
Insured's Name: _____ Relation _____
Insured's Birth date ____/____/____ Insured's ID # _____
Insured's Employer: _____
Employer's Address: _____
City: _____ St. _____ Zip _____

Authorization and Release:
I understand that I am Responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of patient:
_____
Date:
_____

MEDICAL HISTORY

Do You Have a personal Physician? ❑ Yes ❑ No
Physician's Name:_____
Phone#:(_____)_____
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you had any metals rod, pins, or implants? ❑ Yes ❑ No
Are you taking any prescriptions/over the counter drugs? ❑ Yes ❑ No
Please List each One: _____
_____
_____

Have you ever taken Fosamax, or any other Bisphosphonate? ❑ Yes ❑ No
Have you ever taken Phen-fen? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No

For Women Only

Are you using a prescribed method of birth control? ❑ Yes ❑ No
Are You Pregnant? Week#____ ❑ Yes ❑ No
Are You Nursing? ❑ Yes ❑ No
Are you taking any birth control? ❑ Yes ❑ No

Have you ever had any of the followings diseases or medical problems?

Abnormal Bleeding	❑ Yes ❑ No	Herpes /Fever Blisters	❑ Yes ❑ No
AIDS	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Alcohol/Drug abuse	❑ Yes ❑ No	HIV	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Hospitalized for any reason	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No
Artificial Bones/Joints/Valves	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Lupus	❑ Yes ❑ No
Cancer/Chemotherapy	❑ Yes ❑ No	Mitral Valve Prolapsed	❑ Yes ❑ No
Colitis	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Congenital Heart Defect	❑ Yes ❑ No	Psychiatric Problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Difficulty Breathing	❑ Yes ❑ No	Rheumatic/Scarlet fever	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Fainting Spells	❑ Yes ❑ No	Sickle Cells Disease/Traits	❑ Yes ❑ No
Frequent Headache	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Hay Fever	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Heart Attack/Surgery	❑ Yes ❑ No	Tuberculosis (TB)	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Hemophilia	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No		

Please List any serious medical condition(s) that you ever had:

_____
_____
_____

Medications:

List Medications (Prescribed/etc) you are currently taking:

_____
_____
_____

Are you allergic to any of the following:

Aspirin	❑ Yes ❑ No	Jewelry Metals	❑ Yes ❑ No
Codeine	❑ Yes ❑ No	Penicillin	❑ Yes ❑ No
Dental Anesthetics	❑ Yes ❑ No	Tetracycline	❑ Yes ❑ No
Erythromycin	❑ Yes ❑ No	Other	❑ Yes ❑ No

Please list any drugs /materials that you are allergic to:

_____
_____
_____

DENTAL HISTORY

Reason For Today's Visit:_____
_____
Former Dentist:_____
Address:_____
Date Of Last Dental Visit:_____
Date Of Last Dental X-rays:_____

Your Current dental health is ❑ Good ❑ Fair ❑ Poor

Are You currently in Pain? ❑ Yes ❑ No
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No
Have you ever had Periodontal Disease? ❑ Yes ❑ No
Do You now or have ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ? ❑ Yes ❑ No
Are your teeth sensitive to sweets,heat,cold or anything else? ❑ Yes ❑ No
Are your teeth sensitive when biting? ❑ Yes ❑ No
Do you have sores of growth in your mouth? ❑ Yes ❑ No
Do you have any loose teeth? ❑ Yes ❑ No
Do you still have wisdom teeth? ❑ Yes ❑ No
Would You Like Fresher Breath? ❑ Yes ❑ No
Whiter Teeth? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No

If not,what would you change?_____
_____
_____
_____

Authorization and Release:

I have read the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor:

_____

Date:

_____

OFFICE USE ONLY

I verbally reviewed the Medical / Dental Infomation with the patient named herein.

Initials:_____ Date:_____

Doctor's Commets:_____
_____
_____
_____
_____
_____

Office Policies

Dental Appointments
Our goal is to provide quality care to all of our patients. When an appointment is scheduled, a reserved block of Doctor's time has been provided for you and/or your family. We understand your time is valuable and so are your commitments. Please schedule accordingly. A reservation fee WILL be collected at the time of scheduling.

We reserve the right to charge a **$50.00 fee per HR** for any missed or rescheduled dental appointments that have not been cancelled/ rescheduled **48 hours** prior to the scheduled time.

We reserve the right to charge a **$100.00 fee per HR** for any Specialty Appointments missed or rescheduled dental appointments that have not been cancelled or rescheduled **72 hours** prior to the scheduled time.

Due to high demand of our Saturday appointments, limited spacing is available and a **72 hour** notice is required for any cancelled or rescheduled appointments. A **$100.00 fee per HR** will be applied. Once a Saturday appointment is missed, another Saturday will not be appointed.

Confirmation/ Late Appointments
All patients that arrive more than **15 minutes** late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made. **ALL appointments must be confirmed. Failure to do so will result in the appointment being CANCELLED.**

Financial Responsibility
Your signature on this form acknowledges that you, the patient, parent, or legal guardian, agree to bear full financial responsibility for all services provided if;

1. You are determined not to be eligible for insurance coverage.
2. The services are not a covered benefit under your plan.
3. The patient co-payment determined by your insurance plan is to be paid in full at the time of scheduling.
4. Unpaid past due balances may be subject to interest charges.
5. We DO NOT guarantee what insurance will cover. We can only provide an estimate.

Please keep in mind, any financial estimates presented to you for dental treatment, is only an **ESTIMATE** of what your insurance company will pay. We cannot guarantee what insurance will pay. **Financing options are available**

Co-Payments/ Reservation Fee
We will collect either the entire copayment or a portion to reserve an appointment for treatment with the dentist or hygienist. If the appointment is missed or failed to met the office policy, the cancellation fee WILL be deducted from the Reservation Fee.

Returned Checks
A fee of **$35.00** will apply for any checks returned to us for any reason. Future services will require payment by cash or credit card.

Print Name:
_____

Signature: _____ Date: _____

Form 14-208F1

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date Signed)

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- [ ] **Individual refused to sign**
- [ ] **Communications barriers prohibited obtaining the acknowledgment**
- [ ] **An emergency situation prevented us from obtaining acknowledgement**
- [ ] **Other (Please Specify)**

_____

_____

_____

Employee Name: _____

Employee Signature: _____

Date: _____