

PATIENT REGISTRATION

SIMPLY DENTISTRY

LAST NAME: _____ FIRST NAME: _____ MI: _____

PREFERRED NAME: _____ SOCIAL SECURITY #: _____ DOB: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PH: _____ BUS PH: _____ CELL: _____ TEXT OK? Yes No

EMAIL: _____

BY PROVIDING YOUR CELL PHONE NUMBER AND EMAIL, YOU CONSENT TO BEING CONTACTED BY OUR PRACTICE REGARDING TREATMENT AND YOUR ACCOUNT.

MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED WIDOWED

IF THE PATIENT IS A MINOR

PRIMARY RESIDENCE ADDRESS (CIRCLE ONE): BOTH PARENTS MOTHER FATHER STEPPARENT LEGAL GUARDIAN

NAME OF SCHOOL: _____ GRADE: _____

DENTAL INSURANCE

PRIMARY INSURANCE	
INSURANCE COMPANY	
GROUP NO	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S ID NO	
INSURED'S SOCIAL SECURITY NO	

SECONDARY INSURANCE	
INSURANCE COMPANY	
GROUP NO	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S ID NO	
INSURED'S SOCIAL SECURITY NO	

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? NAME: _____ RELATIONSHIP: _____

YOU WERE REFERRED TO US BY: _____

EMERGENCY CONTACT: NAME: _____ PHONE NO: _____ RELATIONSHIP: _____

INFORMATION OF INDIVIDUAL FINANCIALLY RESPONSIBLE (PLEASE COMPLETE IF THE INDIVIDUAL IS OTHER THAN THE PATIENT)

RESPONSIBLE INDIVIDUAL'S NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PH: _____ BUS PH: _____ CELL: _____ TEXT OK? Yes No

EMAIL: _____

DOB: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ EMPLOYER'S ADDRESS: _____

EMPLOYER'S PHONE NO: _____ OCCUPATION: _____

CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Date of Birth _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
If NO, explain _____

2. Yes / No Has there been a change in your health within the last year?
If YES, explain _____

3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

4. Yes / No Are you being treated by a physician now? If YES explain _____
Date of last medical exam _____ Reason for exam _____

5. Yes / No Have you had problems with prior dental treatment?
If YES, explain _____

Date of last dental exam _____ Name of last treating dentist _____

6. Yes / No Are you in pain now?
If YES, explain _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest Pain (ongoing)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea/constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS / HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic Surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other _____

**IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No for each)**

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Other _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No	Are you or could you be pregnant? If YES, what month?
Yes / No	Are you nursing?
Yes / No	Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain: _____ _____
Yes / No	Have you ever been pre-medicated for dental treatment? If YES, why _____ _____
Yes / No	Have you ever taken Fen-Phen? If YES, when _____
Yes / No	Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name _____ Relationship _____ Phone Number _____

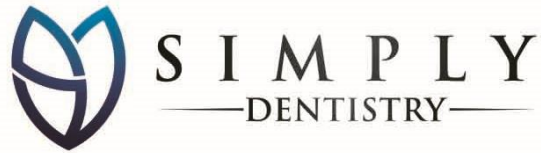
I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)

Date

Signature of Dentist

Date



Consent For Treatment

Simply Dentistry

I HEARBY AUTHORIZE THE DOCTOR OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS FOR MY DENTAL NEEDS.

UPON SUCH DIAGNOSIS, I AUTHORIZE THE DOCTOR 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 GIVE CONSENT TO THE DOCTORS OR DESIGNATED STAFF USE AN DISCLOSURE OF ANY ORAL, WRITTEN OR ELECTRONIC HEALTH RECORDS THAT ARE INDIVIDUALLY IDENTIFIABLE AS MINE FOR THE PURPOSE OF CARRYING OUT OF MY TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT ONLY THE MINIMUM AMOUNT OF INFORMATION NESECCARY TO PROVIDE QUALITY CARE WILL BE USED OR DISCLOSED AND THAT A NOTICE FULLY OUTLINING THE PREOTECTION OF MY PERSONAL HEALTH INFORMATION IS AVAILABLE.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT/RESPONSIBLE PARTY'S SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I _____ (full name), have received a copy of the
Simply Dentistry Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following

Personal Representative's Name _____

Relationship to Patient _____

For Program Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Simply Dentistry
750 Kains Ave
San Bruno, CA 94066

Financial Agreement and Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Towards these goals, we would like to explain the financial and scheduling responsibilities of our practice.

Payment: Payment in full and/or any estimated co-payments are due at the time services are rendered. Financial arrangements and agreements are completed in advance of performing any treatment. We accept the following forms of payment: Vista, MasterCard, Discover, Checks, American Express, Care Credit and cash. If you elect to apply for third-party financing, such as Care Credit, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit plan is a contract between you/ your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you/your employer and the plan. We are happy to help our patients with questions about their dental benefit plans to understand and maximize their coverage. Should the claim be denied or adjusted, the patients and/or guardians (guarantor) will be directly responsible for all financial charges. Should your insurance company fail to pay us on your behalf within 60 days of submitting the claim, we will convert the claim amount as due from you and bill you for the open balance.

Out-Of-Network dental benefit plans: It is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers and /or PPO providers. Our practice can file the claim with your Dental Benefit plan and receive reimbursement directly from the Dental Benefit plan (unless the Dental Benefit plan has stipulated otherwise and/or you as the patient has stipulated no) if you "assign benefits" to our office. In this circumstance, you are responsible to pay the total amount due if your Dental Benefit plan will not allow for "assignment of benefits" to our office,

and/or any estimated co-payments due at the time of service if your Dental Benefit plan does allow assignment of benefits to our office. Keep in mind our estimated out-of-pocket expense and/or estimated co-payment is only an estimate. If our office does not contract with your Dental Benefit plan, we are not given an exact dollar amount for services. Our office can send in a pre-treatment estimate to your Dental Benefit plan for a more accurate out-of-pocket and/or estimated co-payment amount due. Any/all balances not paid by your Dental Benefit plan are the sole responsibility of the patient/or Legal Guardian.

Scheduling of Appointments: We reserve a specific amount of time needed for the Dentist and Hygienist for each procedure. When a patient cancels or reschedules an appointment, we require *48 business hours notice* so we may adjust our schedule accordingly. Notice must be given by phone as we do not accept cancellations via voicemail, email or text messaging. To maintain the utmost service and care, any appointment cancelled or rescheduled without 48 business hours notice is subject to a fee of \$98.00. To also serve our patients in a timely manner, we may need to reschedule your appointment if you are late by more than 20 minutes. A deposit may be required to hold your appointment if you have a history of failed appointments and/or rescheduled appointments without the required 48 business hours notice. This fee will not be refunded should you miss or cancel your appointment without the required 48 business hours notice.

Patient name (Please print)

Patient and/or Legal Guardian Signature and/or Representative

Date