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? O YES O 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 (*CHECK ONE*): ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

IF THE PATIENT IS A MINOR

PRIMARY RESIDENCE ADDRESS (CHECK 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? O YES O NO

EMAIL: ____

DOB: _____________________________ SOCIAL SECURITY #: __________________________

EMPLOYER: ____ EMPLOYER'S ADDRESS: ____

EMPLOYER'S PHONE NO: ______________________________________ OCCUPATION: ____

SIMPLY
DENTISTRY

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: ____

CONFIDENTIAL HEALTH HISTORY

Patient Name____Date of Birth _________________________

I. PLEASE CHECK 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 check 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 check 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 check 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 check 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 check 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

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: Visa, 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 *2 business days 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 *2 business days 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 2 business days notice. This fee will not be refunded should you miss or cancel your appointment without the required 2 business days notice.

____

Patient name (Please print)

____

Patient and/or Legal Guardian Signature and/or Representative

____

Date

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)