WELCOME

Today's Date _______/_______/_____________

Thank you for selecting our dental health care team!
We will strive to provide you with the best possible dental care
To help us meet your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Name ____*Social Sec.#* ________-____-________ *Birth date* ____/____/_____

*Home Phone*_________________________ *Work Phone*________________________ *Cell Phone*____________________________

*Email*____

Address ___________________________________ *Apt* ________ *City* ___________________ *State* _______ *Zip Code*____________

Choose Appropriate Social Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* ***GENDER*** ☐*Male* ☐ *Female*

☐ *Minor* → *If patient is a student, Name of School / College* ____

Address ____ *City* ___________________ *State* ________ *Zip* ________

Whom May We Thank for Referring You? ____

Contact name in Case of Emergency ____ *Phone* _________________

Facebooker, Twitterer, Yelper, and/or Googler: Review us,
Spread the love for Redwood City Dental Care

Responsible Party

Name of Person responsible for this Account ____ *Birth date* ____/____/_____

Relationship to patient ____________________ *Home Phone* ________________________ *Cell Phone*_______________________

Address ___________________________________ *Apt* ________ *City* ___________________ *State* _______ *Zip Code*___________

Driver's License/ State # ____ *Social Security #* ________-________-_________

Employer ____ ***Work Phone*** ________________________________

Is this Person Currently a Patient in our Office? ____ *Yes* ____ *No*

Dental Benefit Information

Name of Insured ____ *Relationship to Patient* _______________________

Birth date _____/_____/_______ *Social Security #* ________-_______-_________ *Member Id #*___________________________

Name of Employer ___________________________________ *Work Phone* _________________ *Date Employed* ____/____/_____

Address of Employer _____________________________________ *City* ____________________ *State* ____ *Zip Code* ____________

Insurance Company ____ *Group #* _________________________________

Insurance Co. Address _________________________ *City* __________ *State* ____ *Zip Code* ______*Phone*__________________

20 Birch Street, Redwood City, CA 94062 Office (650) 701-1111
www.redwoodcitydental.com

Today's Date:__/__/____

MEDICAL AND DENTAL HISTORY

Name ____ Birthday____/____/________

1. Are you in good health? **YES NO**
2. Has there been any change in you general health within the past year? **YES NO**
3. Date of last physical examination____
4. Are you now under the care of a physician or health care professional? **YES NO**

If so, what is the condition being treated?____________________________________

5. Name and address of physician ____

Phone number____

6. Have you had any serious illnesses, operation, or been hospitalized in the past five years? **YES NO**

If so, what was the problem? **YES NO**

7. FEMALES ONLY: Are you pregnant? **YES NO**

Do you take oral contraceptives? **YES NO**

8. DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?(circle all that apply)

SKIN		**HEART / BLOOD VESSELS**		**AEROSOL TRANSMISSIBLE DISEASES**	
* Itching	**YES NO**	* Rheumatic fever	**YES NO**	* SARS	**YES NO**
* Rash/Hives	**YES NO**	* Heart Murmur	**YES NO**	* Meningitis	**YES NO**
* Ulcers	**YES NO**	* Chest Pain	**YES NO**	* Pharyngitis	**YES NO**
* Pigmentation or skin color change	**YES NO**	* Heart attack	**YES NO**	* Pneumonia	**YES NO**
* Lack or loss of body hair	**YES NO**	* Shortness of breath	**YES NO**	* Diphtheria	**YES NO**
EYES/EARS /NOSE/THROAT		* Swelling of ankles	**YES NO**	* Rubella	**YES NO**
* Visual change/blurring	**YES NO**	* High/Low blood pressure	**YES NO**	* Parvovirus B19	**YES NO**
* Glaucoma	**YES NO**	* Congenital heart disease	**YES NO**	* Mumps	**YES NO**
* Loss of hearing	**YES NO**	* Prosthetic valves	**YES NO**	*Pertussis/Whooping Cough	**YES NO**
* Ringing in ears	**YES NO**	* Heart Surgery	**YES NO**	*Haemophilus Influenzae Type B	**YES NO**
* Frequent ear infection	**YES NO**	* Pacemaker	**YES NO**	*Viral Hemorrhagic Fevers	**YES NO**
* Frequent nose bleeds	**YES NO**	**GENITOURINARY**		* Group A Streptococcus	**YES NO**
* Sinus Problems	**YES NO**	* Kidney Disease	**YES NO**	* Mycoplasmal Pneumonia	**YES NO**
NERVOUS SYSTEM		* Kidney transplant/dialysis	**YES NO**	* Avian Flu	**YES NO**
* Frequent headaches	**YES NO**	* Difficulty/pain on urination	**YES NO**	* Anthrax	**YES NO**
* Dizziness/fainting	**YES NO**	* Blood in urine	**YES NO**	* SmallPox	**YES NO**
* Epilepsy/seizures/convulsions	**YES NO**	* Frequent Urination	**YES NO**	* Seasonal Flu	**YES NO**
* Neuritis/neuralgia	**YES NO**	* Sexually transmitted disease	**YES NO**	* Novel H1N1 Flu	**YES NO**
* Parasthesias/numbness/tingling	**YES NO**	* Syphilis	**YES NO**	* Shingles	**YES NO**
* Paralysis	**YES NO**	* Gonorrhea	**YES NO**	* Chicken Pox	**YES NO**
* Hydrocephalic shunt	**YES NO**	* Herpes	**YES NO**	* Measles	**YES NO**
DIGESTIVE SYSTEM		**PSYCHIATRIC**		* Tuberculosis	**YES NO**
* Hepatitis	**YES NO**	* Nervousness	**YES NO**	* Emphysema/bronchitis	**YES NO**
* Jaundice	**YES NO**	* Irritability	**YES NO**	* Asthma/wheezing	**YES NO**
* Liver Disease	**YES NO**	* Depression/excessive worry	**YES NO**	**ENDOCRINE (GLANDS)**	
* Ulcers	**YES NO**	* Nervous breakdown	**YES NO**	* Diabetes	**YES NO**
* Change in appetite	**YES NO**	**BLOOD / LYMPH / IMMUNE**		* Thyroid trouble/goiter	**YES NO**
* Black or bloody stools	**YES NO**	*Easy bruising/excessive bleeding	**YES NO**	* Weight Change	**YES NO**
BONE / MUSCLES		* Persistent swollen glands	**YES NO**	* Excessive thirst	**YES NO**
* Bone Deformity/fracture	**YES NO**	* Blood transfusion	**YES NO**	**OTHER**	
* Arthritis/rheumatic	**YES NO**	* Hemophilia	**YES NO**	* Radiation therapy	**YES NO**
* Artificial joint	**YES NO**	* Anemia/sickle cell	**YES NO**	* Chemotherapy	**YES NO**
* Muscle weaknesses/pain	**YES NO**	* HIV positive	**YES NO**	* Tumors or growth	**YES NO**
GENERAL		* AIDS	**YES NO**	* Cancer	**YES NO**
* Tire easily	**YES NO**	* Leukemia	**YES NO**	* Alcohol use	**YES NO**
* Weakness	**YES NO**	* Spleen problems	**YES NO**	* Tobacco use	**YES NO**
* Night Sweats	**YES NO**				
* Persistent fever	**YES NO**				

12. Do you have or have you ever had any of the following (circle all that apply)

*Facial Pain	**YES NO**	*Limited Jaw Motion	**YES NO**	*Headaches	**YES NO**
Joint Sounds-popping/clicking	**YES NO**	*Muscle Spasms	**YES NO**	*Jaw Locking	**YES NO**

13. Are you allergic or have experienced allergic reaction to any of the following? (circle all that apply)

* Local anesthetics (e.g. novocaine) **YES NO**
* Penicillin/other antibiotics **YES NO**
* Sulpha drugs **YES NO**
* Barbiturates/sedatives/ other sleeping pills **YES NO**
* Iodine **YES NO**
* Latex, rubber gloves/dam **YES NO**
* Aspirin **YES NO**
* Codeine or any other narcotics **YES NO**
* Other___________________________

14. Are you taking or using any of the following? (circle all that apply)

* Antibiotics/sulfa drugs **YES NO**
* Blood thinners **YES NO**
* Aspirin **YES NO**
* Blood pressure medication **YES NO**
* Digitalis/other heart drugs **YES NO**
* Nitroglycerin **YES NO**
* Insulin/other diabetes drugs **YES NO**
* Cortisone/steroids **YES NO**
* Thyroid medicine **YES NO**
* Antithistamenes/allergy medications **YES NO**
* Recreational drugs **YES NO**
* Other___________________________

Have you ever taken or taking now Phenphen **YES NO**

Have you ever taken or taking now **Bisphosphanates** (ex: Fosamax) **YES NO**

List all medications and dosages below:

____

____

____

15. Do you have any disease, condition, or problem not listed above that you should tell the dentist? **YES NO**

Please Explain: ____

____

16. Do you have or have you ever had any of the following

* Dental pain **YES NO**
* Bleeding gums/periodontal disease **YES NO**
* Blisters/ulcers/cold sores **YES NO**
* Swelling/lumps in mouth **YES NO**
* White coating on tongue **YES NO**
* Problem with tonsils/ adenoids **YES NO**
* Clicking/popping jaw **YES NO**
* Difficulty opening/closing **YES NO** jaw **YES NO**
* Pain in or near ears **YES NO**
* Sinus trouble **YES NO**
* Injury to face/jaw **YES NO**
* Surgery to face/jaw **YES NO**
* Loose teeth **YES NO**
* Sensitive teeth **YES NO**
* Clenching/grinding teeth **YES NO**
* Shifting of teeth **YES NO**
* Dissatisfied with appearance of teeth **YES NO**
* Ortho treatments braces) **YES NO**
* Other___________________________

17. Are you interested in a screening appointment in the Orthodontic (braces) Clinic? ***YES NO***

18. Does dental treatment makes you **nervous**? **YES NO**

19. Have you had difficulties with past dental treatment? **YES NO**

Please Explain: ____

20. Have you ever had Botox and/or Juviderm___________? if YES date: ________________________

I think I need implant to :(Check all that applies and explain.)

1- Eat Better__________2- Look Better__________3- Speak Better____________4- Get rid of Dentures___________

Sleep Questionnaire

1. Do you snore? Don't know Yes No
2. Is your snoring interrupted by pauses or choking? Yes No
3. Has anyone ever said that you stop breathing or gasp during your sleep? Yes No
4. Do you often feel fatique, exhausted or tired? Yes No
5. Do you wake up during the night or in the morning with headaches? Yes No
6. Have you ever nodded off or fallen asleep while driving? Yes No

Do you have any concerns? :____

I certify that to the best of my knowledge the above information complete and accurate.

If there are any changes in my health, or medicines, I will inform my dentist at the next appointment visit.

Patient signature ___________________________________ ***Date***______________

Doctor signature ____________________________________ ***Date***______________

##

Medical/Dental history update (done at each recall visit):

Date	*Comments*	*Patient Signature*

Please Handle Me with Care

Put a check mark in the box next to the statement that concerns you or describes your problem. Then share this information with your dental team.

- ❑ I gag easily.
- ❑ I feel out of control when I'm lying down in the dental chair.
- ❑ I have not been to the dentist for a long time, and I feel uncomfortable about what you will say about my teeth and my dental hygiene.
- ❑ Pain relief is a top priority for me.
- ❑ I don't like shots (or I've had a bad reaction to shots).
- ❑ Please tell me what I need to know about my mouth in order to make an informed decision.
- ❑ My teeth are very sensitive.
- ❑ I don't like the sound of that tool that makes the picking and scraping noise. It's like someone is scratching fingernails on a blackboard.
- ❑ I don't like cotton in my mouth.
- ❑ I hate the noise of the drill.
- ❑ Please respect my time. I don't want to be left sitting in the reception area.
- ❑ I want to know the cost up front. No money surprises please.
- ❑ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ❑ I have health problems and questions that we need to discuss.

CONSENT FOR TREATMENT

1. I hereby 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 of (name of patient)_________________________’s dental needs.

2. 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.

3. 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.

4. I give consent to the doctor or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

____

Signature of Patient or Responsible Party   Date

____

Witness   Date

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FINANCIAL POLICY

Thank you for choosing Redwood City Dental Care as your dental provider. We are committed to the success and quality of your treatment.

PATIENTS WITH DENTAL BENEFITS

The benefits provided by your dental insurance company are provided in order to aid in payment for dental treatment, and are not intended to cover all dental treatment in full. We cannot guarantee that your dental insurance provider will cover all services offered in this practice. Your insurance policy is a contract between you and your employer. Redwood City Dental Care has no ruling over the benefits provided.

Patients who have HMO Insurance must pay us in full at the time of treatment. After a claim has been received and processed by their limited benefits, the insurance carrier might reimburse you directly. **Patients with any other insurance carrier must pay their co-payment and/or deductible at the time of treatment.**

PAYMENT OPTIONS

1) Pay for treatment rendered at time of visit. We accept Cash, Check, Debit, Visa, MasterCard, American Express, and Discover Card.
2) If your treatment plan totals $500.00 or higher, you may prepay your treatment plan in full, with **cash** or **check**, and receive a 5% administrative courtesy discount, or pay with a **credit card** and receive a 2% discount.
3) If your treatment plan totals $1,000.00 or higher, we offer an extended payment plan. Minimum monthly payments will be determined according to credit approval.(Credit Card refund will be subject to 10% reduction, in the form of a check)

LATE PAYMENTS

If you do not pay your balance within 30 days of the billing date, a service charge of 1.5% will be added to your account. You are responsible for payments regardless of your insurance company's arbitrary determination of usual and customary fees.

NSF CHECKS

Returned checks will be charged a Non-Sufficient Funds fee of a minimum of $25.00, plus the value of the check.

MISSED AND CANCELLED APPOINTMENTS

Redwood City Dental Care requires a **minimum of 24 hours** (or by 12pm on a Friday for a Monday appointment) for cancelled appointments. **If we are not notified within this time frame, you are subject to a $75.00 charge per missed or cancelled appointment.**

I, (your name)_____________________________, have read the above information and received a copy of Privacy Act Acknowledgment. I understand and agree to Redwood City Dental Care's financial policies.

____ ____________________

Signature of Patient or Responsible Party Date

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Privacy and Your Health Information

Your Privacy Is Important to All of Us

Most of us feel that our health and medical information is private and should be protected, and we want to know who has this information. Now, Federal law

- Gives you rights over your health information
- Sets rules and limits on who can look at and receive your health information

Your Health Information Is Protected By Federal Law

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

What information is protected?

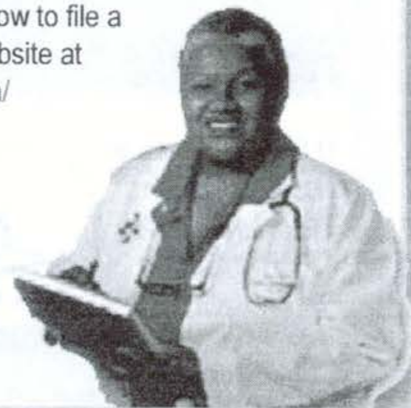
- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint, from the website at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748; the phone call is free.



PRIVACY

The Law Sets Rules and Limits on Who Can Look At and Receive Your Information

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and help run their businesses
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

For More Information

This is a brief summary of your rights and protections under the federal health information privacy law. You can learn more about health information privacy and your rights in a fact sheet called *"Your Health Information Privacy Rights"*. You can get this from the website at www.hhs.gov/ocr/hipaa/. You can also call 1-866-627-7748; the phone call is free.

Other privacy rights

Another law provides additional privacy protections to patients of alcohol and drug treatment programs. For more information, go to the website at www.samhsa.gov.

The Law Protects the Privacy of Your Health Information

Providers and health insurers who are required to follow this law must keep your information private by

- Teaching the people who work for them how your information may and may not be used and shared
- Taking appropriate and reasonable steps to keep your health information secure

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