COMPLETE Comfort DENTAL CARE

2835 Eastern Ave, #3
Sacramento, CA 95821
Ph: (916) 953-6812

Today's Date _____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Ext. _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

PRIMARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? ***Date of last visit*** _____	☐	☐
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☐
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant / heart valve replacement? ***If so, describe where*** _____	☐	☐
7.	Have you ever had general anesthesia?	☐	☐
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
11. Asthma	☐	☐
12. Difficulty breathing?	☐	☐
13. Other lung problems / cough?	☐	☐
14. A Pacemaker / Heart valve replaced?	☐	☐
15. Heart problems?	☐	☐
16. Chest pain?	☐	☐
17. Irregular heart beat?	☐	☐
18. Heart surgery?	☐	☐
19. Stroke?	☐	☐
20. Trouble climbing two flights of stairs?	☐	☐
21. High or Low Blood Pressure?	☐	☐
22. Sleep Apnea / Use CPAP?	☐	☐
23. Bleeding Disorder?	☐	☐
24. Bruise / Bleed easily?	☐	☐
25. Hepatitis / Liver Disease?	☐	☐
26. Faint easily?	☐	☐
27. Seizures?	☐	☐
28. Thyroid Trouble?	☐	☐
29. Diabetes?	☐	☐
30. Kidney problems?	☐	☐
31. Dialysis?	☐	☐
32. High Cholesterol?	☐	☐
33. Arthritis?	☐	☐
34. Osteoporosis?	☐	☐
35. Prosthetic joint?	☐	☐
36. Stomach ulcers / Reflux?	☐	☐
37. Immune system problems?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
38. Slow healing?	☐	☐
39. Tumor or growth?	☐	☐
40. Cancer / Radiation / Chemo?	☐	☐
41. Eye disease / glaucoma?	☐	☐
42. Mental health problems / anxiety / depression?	☐	☐
43. Developmental Delay?	☐	☐
44. Removable dental appliance?	☐	☐
45. Pain or clicking of jaws?	☐	☐
46. Contagious Disease?	☐	☐
47. Any other condition / problem not listed?	☐	☐
48. Other condition: _____		
49. Do you smoke?	☐	☐
50. # packs / day _____		
51. Do you use alcohol?	☐	☐
52. How much? _____		
53. History of illicit drug use?	☐	☐
54. History of dependence or addiction to any substance?	☐	☐
55. HIV?	☐	☐

WOMEN ONLY: *(QUESTIONS 67–70)*

		Yes	No
67.	Is there a possibility of pregnancy?	☐	☐
68.	Expected delivery date? _____		
69.	Are you nursing?	☐	☐
70.	Are you taking birth control pills?	☐	☐

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO
71. Any kind of medication, drug, pills?		
72. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?		
73. Have you ever taken diet pills?		
74. Any natural product, herbal supplement or homeopathic remedy?		
75. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?		
76. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:		

77. Please list any medications you are currently taking. Use the back if necessary. Or, if you have a list, please give it to us & we will make a copy.

Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 8 (eight) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe:

_____

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
78. Local anesthetic (numbing meds.)?		
79. Penicillin?		
80. Other antibiotics?		
81. Sulfa drugs?		
82. Sodium pentothal / Valium / other tranquilizers?		
83. Aspirin?		
84. Amoxicillin?		
85. Codeine or other narcotics?		
86. Other medications?		
87. Latex?		
88. Soy?		
89. Eggs / yolk?		
90. Sulfites?		
91. Do you have any known allergies?		
92. Please list any allergies other than drug allergies:		

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

X _____

Signature of *Doctor*

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that Save Dental is opted out of Medicare and I am entering a private contract for my care.

X _____ X _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X _____

Signature of patient *(Parent or Guardian if Minor)*

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**