CONEJO DENTAL GROUP

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date_____

Whom may we thank for referring you _____

Patient's Name_____ Age____ Birthday_____ ☐ Male ☐ Female
Last First MI

Address _____ Apt #_____
Street

City _____ Zip _____

Home Phone _____ Business Phone_____ Ext _____

Pager Number _____

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Driver's License No _____ Social Security No _____

Employed By _____ Occupation_____

Business Address _____

Spouse Name_____ Birthday_____ Social Security No_____

Spouse Employed By_____ Phone _____

Occupation _____

Name of nearest relative not living with you _____
Address _____ Phone No _____

If patient is a minor:

Father's Name _____ Social Security No_____
Last First MI
Address_____Phone _____

Mother's Name _____ Social Security No_____
Last First MI
Address_____Phone _____

School _____

FINANCIAL INFORMATION

NOTE:The patient and or parent is responsible for dental treatment completed. As a courtesy we will try to help you obtain the maximum coverage from your dental insurance. The patient portion and or co-payment is due the day treatment is rendered or as pre arranged.

Person responsible for this account _____ Soc. Sec.# _____

Address _____ Phone No. _____

PAYMENT PREFERENCE: ☐ Cash ☐ Check Driver Lic.# _____

☐ Visa No. _____ Expires _____

☐ Mastercard No. _____ Expires _____

I authorize **CONEJO DENTAL GROUP** to keep my signature on file and to charge my above charge account for ☐ Recurring charges (on-going treatments) of $ _____

every _____ from _____ to _____

(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Name of Insurance Company (**primary insurance**) _____

Insured Person's Name _____ Date of Birth _____

Social Security No. _____ Relationship _____

Employer _____ Group No. _____

Name of Union _____ Local _____

Name of Insurance Company (**secondary insurance**) _____

Insured Person's Name _____ Date of Birth _____

Social Security No. _____ Relationship _____

Employer _____ Group No. _____ Name of Union _____ Local _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility of the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. **I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services.** If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2 % per month (18% per annum, but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. (This includes a charge for returned checks). **A 24 HOUR NOTICE IS NECESSARY FOR CANCELLATION OR A FEE MAY BE CHARGED.**

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me or at my request, by the Doctor and/or his staff, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended or as previously arranged. I further agree that the reasonable value of said services will be billed unless objected to by me in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Sign _____ Date _____

Patient Name_____

CONEJO DENTAL GROUP

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Physicians Name_____Address_____Phone_____

MEDICAL HISTORY Please answer each question and check the appropriate box **Yes or No**

1. Are you in good health?..... ☐ Yes ☐ No
2. Date of last medical examination _____
3. Are you now under the care of a physician?..... ☐ Yes ☐ No
   If so, what is the condition being treated?_____
4. Have you ever had any serious illness or operation?..... ☐ Yes ☐ No
   If so, explain?_____
5. Have you ever been hospitalized? ..... ☐ Yes ☐ No
   If so, explain?_____
6. Are you taking medicine?..... ☐ Yes ☐ No
   If so, what?_____
7. Are you taking any recreational drugs (marijuana, cocaine, etc)?..... ☐ Yes ☐ No
   If so, what?_____
8. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Other _____
9. **Do you have a Heart Murmur or Mitral Valve Prolapse?..... ☐ Yes ☐ No**
10. **Do you need to be pre-medicated for dental treatment** ?..... ☐ **Yes** ☐ **No**
11. Do you have or have you ever had any of the following?

AIDS/HIV+/ARC	Yes☐No☐	Tuberculosis	Yes☐No☐	Nervous Disorders	Yes☐No☐
Anemia	Yes☐No☐	Emphysema	Yes☐No☐	Mental Disorder	Yes☐No☐
Sickle Cell Disease	Yes☐No☐	Respiratory Disease	Yes☐No☐	Epilepsy or Seizures	Yes☐No☐
Hepatitis or Jaundice	Yes☐No☐	Asthma	Yes☐No☐	Tonsillitis	Yes☐No☐
Hemophilia	Yes☐No☐	Sinus Trouble	Yes☐No☐	Difficulty Swallowing	Yes☐No☐
Bruise Easily	Yes☐No☐	Chicken Pox	Yes☐No☐	Allergies or Hives	Yes☐No☐
Blood Disease	Yes☐No☐	Cold Sores	Yes☐No☐	Diabetes	Yes☐No☐
Excessive Bleeding	Yes☐No☐	Herpes	Yes☐No☐	Kidney Disease	Yes☐No☐
Other Blood Transfusion	Yes☐No☐	Venereal Disease	Yes☐No☐	Liver Disease	Yes☐No☐
Heart Failure	Yes☐No☐	Joint Replacement	Yes☐No☐	Thyroid Disease	Yes☐No☐
Congenital Heart Defect	Yes☐No☐	TMJ Disorder	Yes☐No☐	Glaucoma	Yes☐No☐
Scarlet Fever	Yes☐No☐	Cerebral Palsy	Yes☐No☐	Tumors or Growths	Yes☐No☐
Rheumatic Fever	Yes☐No☐	Artificial Prosthesis	Yes☐No☐	Ulcers	Yes☐No☐
Heart Attack	Yes☐No☐	Rheumatism	Yes☐No☐	Head Injuries	Yes☐No☐
Angina Pectoris	Yes☐No☐	Arthritis	Yes☐No☐	Radiation Treatment	Yes☐No☐
Phen-fen / Redux	Yes☐No☐	Cancer/Leukemia	Yes☐No☐	Drug Addiction	Yes☐No☐
High Blood Press	Yes☐No☐		Yes☐No☐	Other/ Not Listed	Yes☐No☐
Stroke	Yes☐No☐		Yes☐No☐		Yes☐No☐

12. Do you wear a cardiac pacemaker, or have you had heart surgery?..... ☐ Yes ☐ No
13. Do you have any disease, condition or problem not listed ..... ☐ Yes ☐ No
    If so, what?_____
14. Do you smoke?..... ☐ Yes ☐ No
    If so, how much?_____
15. (Women) Are you pregnant?..... ☐ Yes ☐ No
    If so, how many months?_____ Due Date _____
16. (Women) Do you take birth control pills? ..... ☐ Yes ☐ No

Patient Name_____

DENTAL HISTORY

1. What is the purpose of your appointment?_____
2. Are you having any pain? ☐ Yes ☐ No
   If **Yes,** is the area sensitive to heat, cold, sweets, or biting pressure_____
3. Do your gums bleed easily? ☐ Yes ☐ No
4. Do you have a bad taste in your mouth? ☐ Yes ☐ No
5. Do you have offensive breath odor? ☐ Yes ☐ No
6. Have you been treated for gum disease? ☐ Yes ☐ No
7. How many times a **WEEK** do you floss your teeth? _____
8. How many times a **DAY** do you brush ?_____
9. What other oral hygiene aids do you use?_____
10. Do you grind your teeth or have any pain in the joint of your jaw? ☐ Yes ☐ No
11. Are you satisfied with the appearance and color of your teeth ? ☐ Yes ☐ No
12. Do you snore or have a sleeping disorder? ☐ Yes ☐ No
13. Does dental treatment make you nervous? ☐ Yes ☐ No
    ☐ Slightly ☐ Moderately ☐ Extremely
14. Do you have any other concerns regarding your teeth and gums?. ☐ Yes ☐ No
    Explain _____
15. Have you ever had any unfavorable reaction from a local anesthetic? ☐ Yes ☐ No
16. Have you had any serious problems associated with previous dental treatment? ☐ Yes ☐ No
17. How long since your last full mouth X-Rays? ☐ Months ☐ Years
18. How long since your last dental treatment? ☐ Months ☐ Years
19. Have you ever been premedicated with antibiotics for dental treatment? ☐ Yes ☐ No

PREVIOUS DENTIST

Name _____
Address_____
City _____ State _____ Zip _____
Phone _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment.

Signed _____ Date _____ Doctor Signed_____ Date _____

CONSENT FOR TREATMENT: **I understand that the doctor will inform me of any necessary treatment prior to starting treatment.** In the event that work is required I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health Questionnaire form, to administer such analgesics, sedatives, nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services to be rendered are accepted under the terms and conditions printed:

Signed _____ **Date** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.