Patient Information Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ **Home Phone** _____ **Mobile Phone** _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Medical Plan Information

Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____ **Deductible Amount** _____

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)* _____

☐ Advertisement _____ ☐ Local Dental Society _____

☐ Our Web site ☐ Other _____

Please list other members of your immediate family who are patients in our practice

_____ _____ _____ _____

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

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment _____
** Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.*

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, 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. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $ 50.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $ 50.00 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____ (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) _____ (initial)

I hereby acknowledge that a copy of this practice'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. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date _____

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

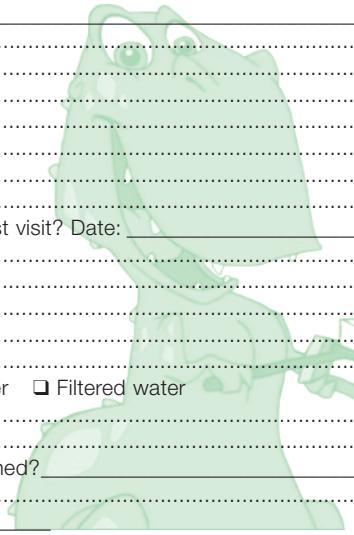
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

Patient Consent for Electronic Communication

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that **Cajalco Dental** may send to you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement

I_____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address_____

Patient's Date of Birth (for verification purposes)_____

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

Information about my invoice or accounts payable. _____(initials)
Information about a specific dental visit. _____(initials) Specify_____
Information about any dental visit. _____(initials)

Acknowledgement

You must acknowledge each of the following before we can send communications electronically.

_____All electronic communications from our practice will be encrypted.

_____I am responsible for providing the dental practice any updates to my email address.

_____I am able to receive information electronically and store it securely away from any public computer.

_____I can withdraw my consent to electronic communications by calling 951-280-9073.

Patient's Signature_____Date_____

CAJALCO
dental
family and cosmetic dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

For Office 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

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____