Steven Adame, DDS and Raul Montalvo DDS

(separate and distinct unrelated entities but choose to share common paperwork for convenience as they share office space)

Patient Information

(This information is necessary for our files and will be considered ***CONFIDENTIAL*** under the Health Information Portability and Accountability Act)

Last Name	
First Name/ Middle Initial	
Home Address	
City/State/Zip	
Social Security No. (for Insurance Purposes)	
Home Phone	( ) –
Cell Phone	( ) –
Employer	
Work Phone	( ) –
E-mail Address	
Gender	☐ Male ☐ Female ☐ _____
Birth Date	MM / DD / YYYY
Source of Referral (if any)	

Your Dental Insurance	Through:	☐ Your Employer ☐ Individually-Owned
	Insurance Company:	
	Group Number:	
	Insurance ID (if not SSN):	
Spouse/Other Dental Insurance	Subscriber is:	☐ Spouse ☐ Self ☐ Other
	Full Name of Spouse/Other:	
	Date of Birth of spouse/other:	MM / DD / YYYY
	Insurance Company:	
	Group Number:	
	Insurance ID/ SSN	

The above information is correct to the best of my knowledge and belief.

Signed: _____ Date: _____

Relationship to Patient (if Surrogate): _____

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FINANCIAL AND POLICY ACKNOWLEGEMENT, AND CONSENT TO TREATMENT

We ask that you ***read and initial*** each of the following policies. ***Your initials and signature at the bottom indicate that you have read, understand, and agree to each,*** so please ask questions if you need clarification.

_____ **PERSONAL FINANCIAL RESPONSIBILITY**: In general, I understand services furnished to me (or my dependent) are ***charged directly to me and I am responsible for payment of all such services***, ***whether or not I carry or acquire valid dental insurance***.

_____ **PAYMENTS/DISPUTES/WAIVER FOR BREACH**: I agree to pay for all services at the time performed, unless credit is extended under specified terms (see section on Insurance below), in which case I will pay ***within 30 days of billing***. I understand the office accepts a personal check, most major Credit Cards (as well as by Debit or Checkcards that can be used like these credit cards without a "PIN"), and CareCredit. I will challenge any charges within 30 days of payment or billing, whichever applies. I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver for any further term or condition. I agree that should either the office or I institute legal proceedings regarding amounts owed by me, the prevailing party shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

_____ **INSURANCE**: If I have (or acquire) insurance, I understand the office will attempt to process my claim and extend credit for a reasonable time to allow processing, but ***I may be requested to pay any co-payment, deductible, and/or estimated portion of costs when services are rendered***. If there is a ***significant delay*** in payment by insurance***, I may be asked to pay for the services*** and to resolve the matter directly with the insurance company. I understand that ***dental insurance may NOT always fully cover all services that I may require*** and that ***I remain fully responsible for all services rendered as the office cannot perform services on the assumption charges will be paid by insurance***. I understand the office will offset any charges by amounts paid by insurance and make any adjustments required under the terms and conditions of any insurance with which the office has entered into a contract or agreement. I understand each policy is different and there is no way for the office to know the details of every one. As the owner of the policy, ***I am responsible for knowing what my plan covers and what it does not***, and I agree to pay ***any remaining balance should my insurance eventually not cover a specific service or pays an amount different than what was estimated***. I am also responsible for contacting my insurance company directly should I have questions the office cannot reasonably assist me with or to resolve problems that may arise.

_____ **FUTURE CHANGES TO INFORMATION PROVIDED**: I am responsible for informing the office of any changes in my contact information, any insurance coverage, ***as well as any changes in my medication(s) or health status since my last visit.***

_____ **X-RAYS**: I understand Dr. Adame and Montalvo require performance of a full-mouth series of X-rays on all new patients as part of a complete assessment unless I can provide a set taken within 3 years. In that case, the current status of my teeth will determine the need for X-rays. I will arrange for my previous dentist to forward any prior X-rays. I understand, to the degree permitted by law, ***the office may charge for X-ray processing should I need them forwarded elsewhere, and my prior dentist may similarly charge for this service.***

_____ **ASSIGNMENT OF BENEFITS**: I authorize my insurance company, or represent that the subscriber of a policy under which I am covered authorizes that company, to pay benefits accruing under such policy to the office/dentist.

_____ **AMALGAM (METAL) FILLINGS NOT OFFERED**: I understand Dr. Adame and Montalvo use composite resin (tooth colored) material that bonds with the tooth, not amalgam (metal) filling material, and that the cost of a resin filling is ***approximately 15% higher***. I understand any insurance I may have ***may not fully cover*** the cost of resin fillings, so ***I would be responsible for any balance*** after the office receives what the insurance will pay and applies any required adjustments.

_____ **FEE ESTIMATES**: I understand that fee estimates provided to me are only valid for ***three months*** unless otherwise indicated.

_____ **FINANCE CHARGES**: I understand, to the degree permitted by law, I may be charged 1½% per month (18% per year) or the maximum permissible rate under law, whichever is less, if my account is not paid within 60 days of my treatment date or a date otherwise agreed upon.

_____ **BROKEN APPOINTMENT FEE**: I understand the office has reserved a unit of time especially for me and that the office requires that I give at least 24 hours notice if I need to cancel or reschedule my appointment so that the office may offer the time to someone else. ***I understand there will be a charge for any appointment cancelled or missed without 24 hours notice. The amount is currently $50, but may be increased in the future without further notice.***

_____ **CONTACTS**: I grant my permission for representatives of the office to contact me at home, work, or on a provided cell phone, to discuss matters related my care and responsibilities using reasonable means, including but not limited to telephone, text, and e-mail.

CONSENT: I grant authority to the dentist in charge of my (or my surrogate's) care, subject to ongoing informed consent, to administer or permit to be administered by authorized staff such **anesthetics, sedatives, nitrous oxide sedation, or other medications**, and to perform or permit to be performed by authorized staff **such operations and procedures as may be deemed necessary or advisable** in my (or my surrogate's) diagnosis/treatment.

I have ☐ **received or** ☐ **been offered and refused** a copy of the "California Dental Materials Information Sheet."

I have ☐ **received or** ☐ **been offered and refused** a copy of the Practice's "Notice of Privacy Practices"

I understand the most current versions are available on the practice website: www.stevenadamedds.com or www.raulmontalvodds.com

Name/Guarantor: _____ Signature: _____ Date: _____

Patient (if not Guarantor): _____

***PATIENT NAME*_____**

DENTAL HEALTH HISTORY

IMPORTANT: Your responses are ***REQUIRED*** and, by law, ***CONFIDENTIAL***. They help assure any treatment needed will take into consideration your health status and, for example, things like the potential for ***interactions of drugs***. Please discuss any concerns with your dental professional.

EMERGENCY CONTACT (Update/Provide): Name: _____ Phone:_____

MEDICATIONS, HERBS, AND/OR SUPPLEMENTS

I am ***sensitive or allergic*** to:
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Other Substance(s) (Specify):

_____

_____

Please check to indicate "Yes"
- ☐ I take hormones

I have taken (in the past) or take the following drugs:
- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Zometa

(Women only)
- ☐ I take Birth control pills
- ☐ I am currently Pregnant

Please List ***ANY other medications, herbs, or supplements*** you are ***taking or have taken in the last year***.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

For NEW Patients ONLY:

Reason for your visit: ☐ Routine Cleaning/Exam ☐ Damaged Tooth ☐ Pain ☐ Other: _____

How long since your last full mouth X-rays?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never
How long since your last dental examination or treatment?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never
How long since your last routine physical exam?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never

For ALL Patients *(Check **ALL** that you have or have had)*

- ☐ **NONE** of these
- ☐ Hay Fever
- ☐ Herpes or Cold Sores
- ☐ Headaches
- ☐ Sinus Disease
- ☐ Chicken Pox
- ☐ Head Injury
- ☐ Glaucoma
- ☐ Stomach Ulcers
- ☐ Gastric Reflux/Heartburn
- ☐ Arthritis
- ☐ TMJ Disorder
- ☐ Difficulty Swallowing
- ☐ Sleep Apnea or Snoring
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Other Heart Disease
- ☐ Stroke
- ☐ Easy Bruising or Bleeding
- ☐ High/Low Blood Pressure
- ☐ Angina/Chest Pain
- ☐ Tuberculosis (T.B.)
- ☐ Respiratory/Lung Disease
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Other Liver Disease
- ☐ Cerebral Palsy
- ☐ Autoimmune Disease
- ☐ Drug Addiction
- ☐ Psychiatric Issues
- ☐ Thyroid Conditions
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Diabetes
- ☐ Implant(s)
- ☐ Joint Replacement
- ☐ Osteoporosis
- ☐ Tumors/Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ HIV/AIDS
- ☐ MRSA or Cellulitis
- ☐ Sexually Transmitted Disease

Please list ANY OTHER
Medical Condition you have or have had: _____

Please review all and "CHECK" any question where the answer is "YES:"

- ☐ I need to see a physician regularly (***not just*** routine physicals)
- ☐ I have required surgery or hospitalization
- ☐ I have ***used or am using*** recreational drugs (e.g., cocaine)
- ☐ I have had a "bad" reaction to a local anesthetic
- ☐ I have had trouble with previous dental treatment
- ☐ I have been "premedicated" prior to dental treatment
- ☐ I am ***sensitive or allergic*** to latex rubber
- ☐ I get (very) nervous when having dental treatment

Dental Professional Notes/Additions

ATTESTATION(S) of Patient (or Surrogate for minors or legally incompetent patients)**:**
The health history information I have provided is true to the best of my knowledge.

Signature:_____ **Date:**_____

Relationship to Patient: _____