SAN FRANCISCO DENTAL WELLNESS
Cosmetic Dentistry • Dental Sleep Medicine

Reset Form

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ❑ YES ❑ No If yes, please list below:

_____

_____

Are you in good health? ❑ YES ❑ No

Date of last medical exam: _____

Have you ever been hospitalized? ❑ YES ❑ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ❑ YES ❑ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ❑ YES ❑ No

Have you had an allergic reaction to Bananas? ❑ YES ❑ No

Do you smoke or chew tobacco? ❑ YES ❑ No

Have you had Heart Surgery? ❑ YES ❑ No

Are you now under the care of an MD? ❑ YES ❑ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ❑ YES ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ YES ❑ No

Are you pregnant? ❑ YES ❑ No Expected delivery date: _____

Are you nursing/breastfeeding? ❑ YES ❑ No

Is there a possibility of pregnancy? ❑ YES ❑ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dental History Information

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ YES ❑ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑ YES ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ YES ❑ No

Have you ever had complications from an extraction? ❑ YES ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ YES ❑ No

Are you prone to frequent headaches? ❑ YES ❑ No

Do you grind or clench your teeth? ❑ YES ❑ No

Do you have sores, blisters or swelling on your gums lips or cheeks? ❑ YES ❑ No

Have you ever had orthodontic treatment? ❑ YES ❑ No

Dr. Signature: _____

Do you snore? ❑ YES ❑ No

Do you have problems with bad breath? ❑ YES ❑ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ❑ YES ❑ No

Have you ever used an electric toothbrush? ❑ YES ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ YES ❑ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❑ Whiter
- ❑ Straighter
- ❑ Close space
- ❑ replace black mercury filling with tooth colored restorations
- ❑ repair chipped teeth
- ❑ replace missing teeth
- ❑ less gums showing
- ❑ replace old crowns or caps that don't match

Date: _____

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT: _____ ("patient")

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Practice.

RESPONSIBLE PARTY:

Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

Employer Name: _____

INSURANCE INFORMATION:

Primary Insurance:

Primary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

Secondary Insurance:

Secondary Insurance Name: _____ Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____ Group Number: _____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____ Date: _____

(to be signed even if Patient is also the Responsible Party)