ARCADIA DENTAL GROUP

PATIENT INFORMATION

Name: _____ SS#:_____
Last Name First Name Middle Initial Home Phone #:_____
Address: _____ Cell Phone #:_____
City: _____ State:_____ Zip:_____
Sex: ☐ M ☐ F Age: _____ Birth date: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
E-mail: _____ ☐ Seperated ☐ Divorced ☐ Partnered for _____ years
Patient Employer/ School: _____ Occupation: _____
Employer/ School Address: _____ Employer/ School Phone: _____
Whom may we thank for referring you? _____
In case of emergency who should be notiffied? _____ **Phone:** _____

PRIMARY INSURANCE

Person Responsible for Account:_____
Last Name First Name Middle Initial
Relation to Patient: _____ Birth date: _____ SS#: _____
Address: (If different from patient's) _____ Phone: _____
City: _____ State: _____ Zip: _____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____
Subscriber #: _____ Group #: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes _____ No _____
Subscriber Name:_____
Last Name First Name Middle Initial
Relation to Patient: _____ Birth date: _____ SS#: _____
Address: (If different from patient's) _____ Phone: _____
City: _____ State: _____ Zip: _____
Subscriber Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____
Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions, or necessary appeals. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Medical History

Patient Name:_____ **D.O.B:**_____

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 concerns, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropiate.

1. Are you now under the care of a physician?..... **YES** **NO** If yes, what is the condition being treated?_____
   Physician name/ Phone # / Address _____
2. Have you ever had any serious illness or operation?..... **YES** **NO** If yes, what is the condition being treated?_____
3. Have you ever been hospitalized?..... **YES** **NO** If yes, what is the condition being treated?_____
4. Are you taking medication? **YES** **NO** Any herbal supplements? **YES** **NO** Any recreational drugs? **YES** **NO**
   If so, what? _____ What dosage? _____

Women: Are you
Pregnant/ Trying to get pregnant? ***YES NO*** ***Taking oral contraceptives?*** ***YES NO*** ***Nursing?*** ***YES NO***

Are you sensitive or allergic to any drugs? **YES** **NO** **Please check all that apply.**

☐ Local Anesthetic	☐ Sulfa Drugs	☐ Codeine	☐ Penicillin
☐ Any Metals (nickel, mercury)	☐ Latex Rubber	☐ Aspirin	**If other, what drug(s)?** _____

7. Do you have, or have you had any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Anemia
☐	☐	Liver Disease	☐	☐	Joint Replacement	☐	☐	Epilepsy	☐	☐	Cortisone Medicine
☐	☐	Heart Ailments/ Attacks	☐	☐	High Blood Pressure	☐	☐	Allergies or Hives	☐	☐	Rheumatic Fever
☐	☐	Hepatitis or Jaundice	☐	☐	Low Blood Pressure	☐	☐	Radiation Therapy	☐	☐	Arthritis
☐	☐	Excessive Bleeding	☐	☐	Sinus Trouble	☐	☐	Blood Disease	☐	☐	Chemotherapy
☐	☐	Drug Addiction	☐	☐	Glaucoma	☐	☐	Seizures	☐	☐	Pain in Jaw Joints
☐	☐	Emphysema	☐	☐	Fainting Spells	☐	☐	AIDS Related Complex	☐	☐	Nervous Disorders
☐	☐	Venereal Disease	☐	☐	Tuberculosis (TB)	☐	☐	Cardiac Pace Maker	☐	☐	Asthma
☐	☐	Respiratory Disease	☐	☐	Kidney Disease	☐	☐	S.T.D	☐	☐	Head Injuries
☐	☐	Thyroid Disease	☐	☐	Cold Sores	☐	☐	Bruise Easily	☐	☐	Diabetes
☐	☐	Hemophilia	☐	☐	Artificial Prosthesis	☐	☐	Angina Pectoris	☐	☐	Cerebral Palsy
☐	☐	Congenital Heart Lesions	☐	☐	Mental Disorder	☐	☐	Psychiatric Treatment	☐	☐	Leukemia
☐	☐	Prosthetic Joints	☐	☐	Tumors or Growths	☐	☐	Blood Transfusions	☐	☐	Swollen Ankles
☐	☐	Mitral Valve Prolapse	☐	☐	Stroke	☐	☐	Heart Disease	☐	☐	H.I.V
Have you ever had any serious illness not listed above?						☐	☐	If yes, what?_____			

9. Do you smoke? If yes, how much per day?..... **YES** **NO** _____
10. Do you consume alcohol? If yes, how often?..... **YES** **NO** _____
11. Have you ever taken the drug Phen-Phen?..... **YES** **NO**

Dental History

1. Have you ever had local anesthetic? …….. **YES** **NO**
2. Have you ever had any unfavorable reaction from a local anesthetic? …… **YES** **NO**
3. Have you had any serious trouble associated with any previous dental treatment? **YES** **NO**
   If so, please explain _____
4. How long since your last full mouth x-rays? _____
5. How long since your last dental treatment? _____
6. Is any current dental problem the result of an accident? YES NO If yes, when?_____
7. Have you ever experienced any of the following problems in your jaw?
   Clicking…… **YES** **NO** Pain (joint, ear, side of face)…… **YES** **NO**
   Difficulty in chewing…… **YES** **NO** Difficulty in opening or closing your jaw….. **YES** **NO**
8. Do your gums bleed while brushing or flossing? …….. **YES** **NO**
9. Are your teeth sensitive to sweet, sour, hot or cold liquids/food? …… **YES** **NO**
10. Do you clench or grind your teeth? …… **YES** **NO**
11. Do you like your smile? …… **YES** **NO**
12. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderate ☐ Extremely

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.

Patient Signature:_____ Date:_____ DDS Signature:_____ Date:_____

Arcadia Dental Group

Financial Policy

At Arcadia Dental Group, our goal is to provide quality dentistry at a fair price and a healthy and happy environment for all of our patients. We provide our services with honesty and integrity and expect the same from those we serve.

A $25.00 charge will be made for all missed appointment that are not cancelled or rescheduled at least 24 hours prior to the scheduled appointment time.

As a service to our patients we submit dental claims to their insurance for payments. We ask that each patient pay their deductible and or estimated portion at the time of service unless alternate arrangements have been made. If for any reason, the insurance company does not pay estimated amount, it becomes the patient share. Please monitor insurance payments. Our payment options include Cash, Care Credit, Visa, and MasterCard.

Our goal is to provide the best treatment possible for our patients and we charge the usual and customary rates in our area. To do so the patients is responsible for paying the balance in full regardless of the insurance company's determination of usual and customary rates.

I have read, understand, and agree to the above Financial Policy regarding my payments and insurance obligations. I will notify Arcadia Dental Group if any changes on insurance, address, or phone numbers occur.

Patient's Name: _____

DOB: _____

Patient/Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICE

Patient Acknowledgment of Receipt

Arcadia Dental Group

The Healthcare Notice Privacy Practices recognizes that patients have the Rights to Privacy concerning their health information. We make every effort to protect and preserve patients in a manner that secures this information.

By signing this acknowledgement:

You are only confirming that you understand the Privacy Practices of this office.

Print your Name: _____

Sign your Name: _____

Today's Date: _____