# Rocklin Smiles

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3420 Sunset Blvd ●Rocklin CA 95677 (916)624-3119

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: Male □ Female □ Family Status: Married □ Single □ Child □ Other □
Mr./Ms/Mrs./Etc

Birth Date: _____ SSN: _____-____-_____ Email Address: _____

Phone: _____ _____ _____ _____ _____ _____
Home Cell Work Ext. Fax Other

Address_____ _____ _____ _____
Address City State Zip Code

Person we may contact in an emergency: Name, Phone Number and Relationship:

_____

Name of person we may thank for referring you to our practice.

_____

## Financial Responsibility Party Information

The Following is for: The patient's spouse □ the person responsible for payment □ both □ neither □

Name_____ _____ _____ _____
Last First MI Preferred Name

Birth Date: _____ SSN: _____-____-_____ Email Address: _____

Phone: _____ _____ _____ _____ _____ _____
Home Cell Work Ext. Fax Other

Address_____ _____ _____ _____
Address City State Zip Code

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

As we value your time, we ask that you value ours. A 48 hour notice is required for changes in your appointment date and time. If you need to cancel within the 48 hours then a $50.00 per hour charge will be placed on your account.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I will be responsible for all legal and or collection fees for all unpaid balances on this account. A service charge of 1.5% (percent) per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

## Primary Dental Insurance Information

**Please take a moment to enter you, and/or dependent(s) current PRIMARY dental insurance information so that we may help assist with the filing of any dental insurance claims. We are glad to help with this service, at no additional charge to you.**

Patient Name_____ _____ _____ _____
Last First MI Preferred Name

Name of Insured: _____ _____ _____
Last First MI

Insured Birth Date_____ ID#_____ SSN: _____ Group#_____

Insured's Address: _____ _____ _____ _____
Address City State Zip Code

Insured's Employer Name:_____

Employer Address: _____ _____ _____ _____
Address City State Zip Code

Patients Relationship to insured: Self □ Spouse □ Child □ other □ _____

Insurance Plan Name: _____

Insurance Address: _____ _____ _____ _____
Address City State Zip Code

## Secondary Dental Insurance Information

**Please take a moment to enter you, and/or dependent(s) current SECONDARY dental insurance information so that we may help assist with the filing of any dental insurance claims. We are glad to help with this service, at no additional charge to you.**

Patient Name_____ _____ _____ _____
Last First MI Preferred Name

Name of Insured: _____ _____ _____
Last First MI

Insured Birth Date_____ ID#_____ SSN: _____ Group#_____

Insured's Address: _____ _____ _____ _____
Address City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____ _____ _____
Address City State Zip Code

Patients Relationship to insured: Self □ Spouse □ Child □ other □ _____

Insurance Plan Name: _____

Insurance Address: _____ _____ _____ _____
Address City State Zip Code

## Medical Health History

What is your estimate of your general health? Excellent □ Good □ Fair □ Poor □

Are you currently under the care of a physician? Yes□ No □

Most recent physical examination/and purpose of exam? _____

Name and phone Number of physician and their specialty? _____

Pharmacy of choice if a prescription is needed: Location, phone number and medical records number if necessary: _____

Please list any surgery, illness or injury: (year/month)

_____

_____

### Female Patients:

- Are you currently on any type of birth control? □ Yes □ No
- Are you currently pregnant or do you think you might be? □ Yes □ No

**Please check below each box to any/all allergies or medical conditions that apply to your medical health. Please make sure to check each box individually so we know that you saw all possible conditions. Do you have or have you ever had:**

| | | | |
|---|---|---|---|
| Acid reflux/GERD | □ Yes □No | Cold sores/viral | □ Yes □No |
| AIDS/HIV | □ Yes □No | Diabetes | □ Yes □No |
| Allergy aspirin | □ Yes □No | Emphysema | □ Yes □No |
| Allergy codeine | □ Yes □No | Epilepsy/seizures | □ Yes □No |
| Allergy erythromycin | □ Yes □No | Fainting/dizziness | □ Yes □No |
| Allergy fluoride | □ Yes □No | Fibromyalgia | □ Yes □No |
| Allergy ibuprofen | □ Yes □No | Frequent headaches | □ Yes □No |
| Allergy latex | □ Yes □No | Glaucoma | □ Yes □No |
| Allergy metals | □ Yes □No | Head/neck injuries | □ Yes □No |
| Allergy penicillin | □ Yes □No | Heart Condition | □ Yes □No |
| Allergy sulfa | □ Yes □No | Hemophilia | □ Yes □No |
| Allergy tetracycline | □ Yes □No | Hepatitis A, B, or C | □ Yes □No |
| Allergy Vicodin/Norco | □ Yes □No | High Blood Pressure | □ Yes □No |
| Allergy Tylenol | □ Yes □No | High Cholesterol | □ Yes □No |
| Anemia | □ Yes □No | Hormone deficiency | □ Yes □No |
| Artificial joints | □ Yes □No | Hypoglycemia | □ Yes □No |
| Anxiety/nervousness | □ Yes □No | Kidney disease | □ Yes □No |
| Arthritis | □ Yes □No | Leukemia | □ Yes □No |
| Asthma | □ Yes □No | Liver disease | □ Yes □No |
| Blood thinners | □ Yes □No | Low blood pressure | □ Yes □No |
| Blood transfusion | □ Yes □No | Lupus | □ Yes □No |
| C.O.P.D. | □ Yes □No | Nut Allergies | □ Yes □No |
| Cancer | □ Yes □No | Osteoporosis | □ Yes □No |
| Chemotherapy | □ Yes □No | Parathyroid disease | □ Yes □No |
| | | Prostate disorder | □ Yes □No |

| | | | |
|---|---|---|---|
| Radiation therapy | □ Yes □No | Taking medication for weight Management (i.e. fen-phen) | □ Yes □No |
| Sensitivity to epinephrine | □ Yes □No | Taking bisphosphonates | □ Yes □No |
| Sickle cell anemia | □ Yes □No | Thyroid disease | □ Yes □No |
| Sinus/snoring issues | □ Yes □No | TMJ | □ Yes □No |
| Sleep disorders | □ Yes □No | Tobacco use | □ Yes □No |
| Steroid therapy | □ Yes □No | Tuberculosis | □ Yes □No |
| Stomach ulcers | □ Yes □No | Tumors or Growths | □ Yes □No |
| Stroke | □ Yes □No | | |

If yes to artificial joints, please indicate specifically which joint(s) and when the surgery

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If yes to asthma, do you use an inhaler? And do you always carry it with you?

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If yes to cancer, what kind of cancer? When were you diagnosed with the cancer? Are you still receiving active treatment for the cancer?

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If yes to diabetes, what type of diabetes? Are you insulin dependent?

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If yes to tobacco use, please indicate what kind, and how much you consume in each time?

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**Do you suffer from any psychological disorders such as:**

| | | | |
|---|---|---|---|
| ADHD * | □ Yes □No | Depression * | □ Yes □No |
| Alcohol/drug dependency * | □ Yes □No | Eating disorder * | □ Yes □No |
| Bipolar * | □ Yes □No | Schizophrenia * | □ Yes □No |
| Dementia * | □ Yes □No | Other * | □ Yes □No |

# Do you have or have you ever had heart related issues such as:

| | | | |
|---|---|---|---|
| Angina | □ Yes □No | Heart attack | □ Yes □No |
| Arteriosclerosis/hardening of the arteries | □ Yes □No | Heart murmur | □ Yes □No |
| Artificial heart valve/repaired heart defect (PFO) | □ Yes □No | History of infective endocarditis | □ Yes □No |
| Cardiac stent within the last six months | □ Yes □No | Mitral valve prolapse | □ Yes □No |
| Congenital heart failure | □ Yes □No | Rheumatic fever/Scarlett fever | □ Yes □No |

Is pre-medication required before dental visits due to a heart condition, cancer treatment, artificial joint placement, or organ transplant? □ Yes □No

If yes, please include medical doctor's information and/or medication prescribed:_____

_____

List any medications, supplements, and/or vitamins taken within the last two years, if none please write none.

_____

_____

Please ask for an additional sheet of paper to list medications if necessary

## Dental History

How would you rate the condition of your mouth? □ Excellent □Good □Fair □Poor

I routinely see my dentist every: □ 3 Months □ 4 Months □6 Months □12 Months □ Not routinely

Previous Dentist:_____

Date of most recent dental exam and/or X-rays: _____

Date of most recent dental treatment (other than a routine cleaning): _____

What is your immediate dental concern: _____

_____

**Please check all boxes to the best of your knowledge that describe you and your dental health or history:**

## Personal History

□ I am fearful of dental treatment?
□ I have had complications from past dental treatment
□ I have or had braces, orthodontic treatment or had my bite adjusted?
□ I have had an unfavorable dental experience?
□ I have had trouble getting numb or reaction to local anesthetic?
□ I have had some of my teeth removed?

## Gum and Bone

□ I have been diagnosed or treated for periodontal (gum) disease?
□ I have experienced gum recession?
□ There is a history of periodontal disease in my Family?
□ My gums bleed when brushing, flossing or eating?
□ My teeth are becoming loose.
□ I have noticed an unpleasant taste or odor in my mouth?
□ I have experienced a burning sensation in my mouth?

## Bite and jaw joint

□ I do/would have problems chewing gum?
□ I do/would have problems chewing bagels or other hard foods
□ My teeth have changed in the last 5 years, become shorter, thinner or worn
□ My teeth are crowding or developing spaces
□ I have more than one bite or I clench (squeeze) to make my teeth fit together
□ I have problems with sleep or wake up with an awareness of my teeth
□ I have problems with my jaw joint (pain, sounds, limited opening, locking, popping jaw)
□ I have tension headaches or sore teeth
□ I wear or have worn a bite appliance

## Smile Characteristics

□ There are things about the appearance of my teeth that I would like to change?
□ I have whitened (bleached) my teeth?
□ I am self-conscious about my teeth
□ I have been disappointed with the appearance of previous dental work?

## Tooth Structure

□ I have had cavities within the last 3 years?
□ I have a dry mouth?
□ I have a tooth or teeth that are sensitive to hot, cold, biting or sweets?
□ I have or had a toothache, cracked filling, broken, chipped or cracked tooth?
□ I avoid brushing part of my mouth?
□ I feel or notice holes (i.e. pitting) in my tooth or teeth?

Is there anything important about your medical or dental condition we have not asked? □ Yes □ No

If yes, please describe: _____
_____
_____

I understand the above information is necessary to provide me with optimal dental care in a safe and efficient manner. I have answered all the above medical and dental health questions and information to the best of my knowledge. I acknowledge that Rocklin Smiles has a copy of the Dental Materials Fact Sheet, and the Notice of Privacy Practices available for me at any time upon my request. Rocklin Smiles and staff have my permission to communicate and disclose my personal health and insurance information to respective health care providers or insurance agencies in order to discuss and provide the best treatment possible to me. I will notify Rocklin Smiles of any changes in my health information, medication or insurance information. I grant my permission for Rocklin Smiles to telephone me to discuss my health/dental care or any statement of service.

Signature: _____ Date: _____

*******For Office Use*******

I Have reviewed the above patient information and Medical History Update

Signature: _____ Date: _____

Health History entered into questionnaire by: _____

# Authorization to release and discuss dental information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorized in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do not release information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Rocklin Smiles on my behalf.

Name of authorized person: _____ Relationship_____

Name of authorized person: _____ Relationship_____

Name of authorized person: _____ Relationship_____

____ DO NOT RELEASE INFORMATION TO ANYONE.

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patients Name: _____ DOB: _____

Patient Signature: _____ Date: _____