**Patient Information**

Patient Name: ______________________________________________________Date:_______________
Last First MI (Preferred Name)

□ Male □ Female □ Married □ Single □ Other □ Child

Social Security #: ______________________________ Date of Birth: _________________________________

Phone (Home):__________________ (Work):_________________ ext: _____ (Mobile):__________________

Address: ______________________________________________________________________________
Street Apartment #

_____________________________________________________________________________
City State Zip Code

E-Mail Address: _________________________________________________________________________

**Health Information**

Date of Last Dental Visit: ____________________Reason for Today's Visit: _____________________________

**Have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| □AIDS/HIV | □Fainting | □Nervous Disorders | □Mental Disorders |
| □Allergies:__________ | □Glaucoma | □Pacemaker | □Ulcers |
| □Anemia | □Growths | □Pregnancy, Due Date: ________ | □Venereal Disease |
| □Arthritis | □Hay Fever | □Radiation Treatment | □Codeine Allergy |
| □Artificial Joints | □Head Injuries | □Respiratory Problems | □Penicillin Allergy |
| □Asthma | □Heart Disease | □Rheumatic Fever | □Latex Allergy |
| □Blood Disease | □Heart Murmur | □Rheumatism | □Anesthetic Allergy |
| □Cancer | □Hepatitis | □Sinus Problems | □Past/Present use of Fosamax |
| □Diabetes | □High Blood Pressure | □Stomach Problems | □Past Use of Phen-Phen |
| □Dizziness | □Jaundice | □Stroke | |
| □Epilepsy | □Kidney Disease | □Tuberculosis | |
| □Excessive Bleeding | □Liver Disease | □Tumors | |

□Other:__________________________________________________________________________

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: ___________________________________________________________________

Have you been admitted to a hospital or needed emergency care in the past two years? □ Yes □ No
If yes, please explain: ___________________________________________________________________

Are you currently under the care of a physician? □ Yes □ No
If yes, please explain: ___________________________________________________________________

Name of Physician: _________________________________ Phone: _________________

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: ___________________________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________________________________________ Date: __________________
Signature of Patient, Parent or Guardian

**Whom may we thank for referring you to our practice?** _____________________________________________

**Spouse or Responsible Party Information**

The following is for: □ The Patient's Spouse □The Person Responsible for Payment

Name: ______________________________________________

□Male □Female □Married □Single □Child □Other____________________

Social Security #: ______________________ Date of Birth: ______________________

Phone (Home): ____________ (Work):____________ ext: ______ (Mobile): ____________

Address: ______________________________________________

Street Apartment #

______________________________________________

City State Zip Code

**Employment Information**

The following is for: □ The Patient □The Person Responsible for Payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________________________________

Street City State Zip Code Phone Number

**Insurance Information**

Primary:

Name of Insured: ______________________________ Is the insured a patient? □Yes □No

Last First MI

Insured's Birth Date: ______________ ID#:______________ Group #: ____________

Insured's Address: ______________________________________________

Street City State Zip Code

Employer Name: ______________________ Insurance Plan Name: ______________________

Patient's Relationship to Insured: □Self □Spouse □Child □Other____________________

Secondary:

Name of Insured: ______________________________ Is the insured a patient? □Yes □No

Last First MI

Insured's Birth Date: ______________ ID#:______________ Group #: ____________

Insured's Address: ______________________________________________

Street City State Zip Code

Employer Name: ______________________ Insurance Plan Name: ______________________

Patient's Relationship to Insured: □Self □Spouse □Child □Other____________________

**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends on reimbursements from patients for costs incurred in their care and 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 in cash at time of service. Patients who carry dental insurance understand all services are charged directly to the patient and he/ she is personally responsible for payment of all dental services. Our office will help prepare insurance forms and assist in making collections from insurance and credit any such collections to the patient account. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) will be charged on any account over 60 days unless prior arrangements are made. I understand estimates listed for dental care can only be extended for a period of three months from the date of exam. With consideration to professional services rendered to me, or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor or their assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing within the time of payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee to contact me at home or work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________

Signature of Patient, Parent or Guardian

# Office Policies

**Payment is Due at the Time of Service**

Payment of fees is due at the time of service. Patients with insurance will pay their estimated co-payments before leaving the office. We will provide an estimated treatment plan for each patient to help make the patient aware of out-of-pocket expenses. Our office accepts: cash, debit/credit cards, checks (once approved by TeleCheck), Care Credit and CitiHealth.

**Returned Checks**

If your check is returned for any reason a $25 fee will be added to your account.

**Failure to Pay for Services**

Any patient who does not pay their estimated patient portion at the time of service will be ineligible for further treatment until paid. Any portion left unpaid for over 60 days is subject to finance charges as well as possible assignment to a collection agency.

**Insurance**

Insurance coverage is variable based on the company and the plan. It is the patient's responsibility to know their coverage. We will try our best to contact your insurance company to verify coverage and obtain an explanation of your benefits. The obtained information is not a guarantee of payment from your insurance company. We will bill your insurance company for the fees as a courtesy and collect the estimated patient portion at the time of service. If your insurance company fails to pay the estimated portion, the patient will be billed the difference. We are not responsible for how your insurance company responds to or pays claims, as your benefits are not determined by our office. Some insurance companies require pre-authorizations or waiting periods for certain treatment. It is the patient's responsibility to know about these limitations. Most importantly, please keep us informed of any and all changes to your insurance.

**Prosthodontics**

Crowns, bridges and dentures may require multiple visits to complete, for these procedures; the estimated patient portion is due on the first visit. This fee is non-refundable if the patient does not return for the final delivery.

**Broken or Missed Appointments**

Appointments that are broken or missed without a 24 hour notification are subject to a charge. The first broken or missed appointment will result in verbal or written acknowledgement, the second broken or missed appointment will result in a minimum charge of $45 to each patient and the third broken or missed appointment will result in a minimum charge of $45 to each patient as well as possible dismissal from the practice.

**Tardiness**

If the patient is more than 10 minutes tardy to any scheduled appointment without notice the patient may be rescheduled for another time. The patient is subject to a minimum charge of $45 as well. If tardiness becomes a frequent occurrence the patient may be dismissed from the practice.

**I have read and understand the office policies.**

______________________________________________

Patient or Parent/Guardian Signature Date

## Privacy Disclosure and Dental Materials Fact Sheet

Please sign below to acknowledge that Stanford Ranch Family Dentistry has provided you with a copy of our privacy disclosure (HIPPA) and dental materials fact sheet as requires by California state law.

______________________________________________

Patient or Parent/Guardian Signature Date