DENTAL CARE OF WALNUT CREEK

The information requested below will allow us to correctly establish and/or update your account.
We appreciate your help in making this information as accurate and complete as possible.

PATIENT INFORMATION

Name _____ Birthday _____
Street Address _____ Apt. # _____
City _____ State _____ Zip _____ Driver's License # _____
[ ] Male [ ] Female [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widower/Widow
Employer _____ Occupation _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____

If the same as the patient, write "**SELF**"

RESPONSIBLE PARTY INFORMATION

Name _____ Birthday _____
Street Address _____ Apt. # _____
City _____ State _____ Zip _____ Driver's License # _____
[ ] Male [ ] Female [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widower/Widow
Employer _____ Occupation _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____

INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ] No (If YES, please complete the following information.)

	Primary Insurance	Secondary Insurance
Employer		
Policy issued to		
Social Security #		
Insurance Company		
Insurance ID #		
Group #		
Birthday		

We need the above information so that we can help you obtain the dental insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a pre-determination of benefits, or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

EMERGENCY CONTACTS

Name _____ Phone _____ Relation _____
Name _____ Phone _____ Relation _____

To help us get to know you a little better, please provide the following information

Do you have a nickname? _____
Name of your physician _____ Phone _____
Name of your former dentist _____
What is the purpose for today's visit? _____
Whom may we thank for referring you to our office? _____

DENTAL CARE OF WALNUT CREEK

HEALTH QUESTIONNAIRE

Patient Name_____

01. Is your general health good?	YES	NO
02. Has there been any change in your health within the past year?	YES	NO
03. Are you currently under the care of a physician? If YES, what conditions are you being treated for?	YES	NO
04. Have you ever had a serious illness, operation or hospitalization?	YES	NO
05. Are you currently taking medications? If YES, please list them.	YES	NO
06. Do you use tobacco in any form? If YES, type and frequency usage?	YES	NO
07. Have you ever used recreational drugs? If YES, what and when?	YES	NO
08. Have you ever taken the drugs "Phen-Phen" or "Redux"?	YES	NO
09. (Women) Are you pregnant? If YES, when is the due date?	YES	NO
10. (Women) Are you currently taking birth control pills?	YES	NO

Do you have or have you had any of the following?

CARDIOVASCULAR SYSTEM			ALLERGIES			RESPIRATORY SYSTEM		
Pacemaker	YES	NO	Penicillin	YES	NO	Asthma	YES	NO
Heart Murmur	YES	NO	Sulfa	YES	NO	Bronchitis and/or Emphysema	YES	NO
Mitral Valve Prolapse	YES	NO	Codeine	YES	NO	Tuberculosis (TB)	YES	NO
Artificial Heart Valve	YES	NO	Latex	YES	NO	Sinus Problems	YES	NO
High Blood Pressure	YES	NO	Metal	YES	NO	**NERVOUS SYSTEM**		
Heart Attack and/or Stroke	YES	NO	Local Anesthetics	YES	NO	Dizziness / Fainting / Vertigo	YES	NO
Congestive Heart Failure	YES	NO	Others	YES	NO	Ringing in the ears	YES	NO
Angina Pectoris (Chest Pain)	YES	NO	**URINARY SYSTEM**			Epilepsy / Seizures / Convulsions	YES	NO
Shortness of breath	YES	NO	Kidney Disease	YES	NO	Cerebral Palsy	YES	NO
Ankle Swelling	YES	NO	Venereal Disease	YES	NO	Psychiatric Treatment	YES	NO
Congenital Heart Disease	YES	NO	Burning on Urination	YES	NO	**DIGESTIVE SYSTEM**		
Rheumatic Fever	YES	NO	**BONE / MUSCLES**			Hepatitis (Type)	YES	NO
BLOOD			Artificial Joints / Limbs	YES	NO	Jaundice	YES	NO
AIDS / HIV / ARC	YES	NO	Arthritis / Rheumatism	YES	NO	Ulcers	YES	NO
Anemia	YES	NO	Osteoporosis	YES	NO	**MISCELLANEOUS**		
Blood Transfusion	YES	NO	Bisphospenates	YES	NO	Hay Fever	YES	NO
Bruise easily	YES	NO	**ENDOCRINE SYSTEM**			Tumors or Growths	YES	NO
			Diabetes (Type)	YES	NO	Radiation Therapy / Chemotherapy	YES	NO
			Thyroid Disease	YES	NO			

Do you have any other medical issues not mentioned above?	YES	NO

DENTAL QUESTIONNAIRE

01. Do you have any discomfort, pain or concerns at this time? If YES, please describe.	YES	NO
02. Have you ever had any serious trouble with previous dental treatments? If YES, please describe.	YES	NO
03. When was your last dental visit? Last cleaning?		
04. Have you ever been treated for Periodontal(Gum) Disease or Pyorrhea' Last x-rays taken?	YES	NO
05. Do dental treatments make you nervous? NO SLIGHTLY MODERATELY EXTREMELY		
06. Have you ever had trouble with Local Anesthetic? If YES, please describe.	YES	NO
07. How often do you brush? NEVER ONCE DAILY TWICE DAILY AFTER EVERY MEAL		
08. How often do you floss? NEVER INFREQUENTLY DAILY AFTER EVERY MEAL		
09. Do you like the your smile or the way your teeth looks? If NO, why?	YES	NO
10. Would you be interested in whitening your teeth?	YES	NO
11. Are you currently in Orthodontic treatment? If NO, would you be interested?	YES	NO

Do you currently have any of the following?

Bleeding and/or sore gums	YES	NO	Loose teeth	YES	NO	Clicking/popping noises from jaw	YES	NO
Unpleasant taste and/or bad breath	YES	NO	Sensitive to temperatur	YES	NO	Difficulty opening and/or closing jav	YES	NO
Frequent blisters	YES	NO	Sensitive to sweets	YES	NO	Diagnosed with TMJ problem	YES	NO
Swelling and/or lumps in mouth	YES	NO	Sensitive to biting	YES	NO	Clenching / Grinding	YES	NO
Full or Partial Upper Denture	YES	NO	How old?			Is it comfortable?	YES	NO
Full or Partial Lower Denture	YES	NO	How old?			Is it comfortable?	YES	NO

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient/Parent/Guardian's Signature **X** _____ Date _____

Reviewing Dentist _____ Date _____

Reviewing Dentist Signature/License # _____

DENTAL CARE OF WALNUT CREEK

Patient Responsibility

We are here to provide dental care to meet your needs and maintain good oral health and prevent unnecessary discomfort and pain. Dentistry is not just about people coming in to get their teeth 'fixed.' It's an interaction between the patient and the dentist to spread education on good oral health care. Responsibilities fall not only with the dentist, but with you, the patient, as well. Proper homecare and good habits, alongside regularly scheduled dental checkups, are the foundation to a healthy mouth.

Good communications between you and the dentist will enable each dental visit to be as pleasant as possible. The relationship we have with our patients is very important to us, as we strive to be perceptive and sensitive to the feelings of our patients. Please fill out the forms completely and truthfully to avoid delay of dental treatments; this includes your recent medical and dental histories. If you have had a dental examination done at another office within the past 24 months, please bring any x-rays from the previous office prior to your initial examination. We believe in doing a thorough examination of your mouth and then explaining everything we find to you, both good and not so good. As a patient, it is your responsibility to ask questions and follow through with your treatment.

We do not believe in letting insurance companies dictate your dental treatment, and neither should you. After all, who knows what's best for your teeth, your dentist or the insurance company? Insurance companies will often cover only the most basic and least expensive procedures. You, as a patient, should demand nothing less than ideal dentistry being performed inside your mouth. Procedures done with short term goals in mind will inevitably require redoing not too far in the future. Long term ideal dentistry may cost a little more now, but will last longer and actually cost you less in the long run.

Please treat our staff with respect and courtesy. They are working very hard with your best interest at heart. We are very happy with the confidence you have shown in choosing Dental Care of Walnut Creek as your dental provider.

Financial Responsibility

Although we will do our very best to verify patient eligibility, the ultimate responsibility for verifying and maintaining insurance eligibility with our dental office lies entirely with you, the patient. Retroactive eligibility will not be accepted. Any procedures performed when the patient is not eligible with our office will be the patient's financial responsibility and will be billed to the patient at the full usual and customary rate. It is to your knowledge that the insurance may not cover certain treatment choices and understand and agree that you have final responsibility for your account regardless of the insurance plan.

Full payment is expected prior to starting of treatment, no exceptions given. Monthly payment is available through payment programs offered by Dental Care of Walnut Creek; no outside payment program is accepted. An estimate of your co-payment according to your insurance policy will be given prior to all treatments; the policy is an agreement between you and your insurance carrier. Although we do try to give an accurate estimate for the treatment, you are ultimately responsible for any and all fees which the insurance does not cover. All transactions will be provided on a cash/credit card basis only. Refunds or partial refunds maybe given pending evaluation of your case; not all procedures are eligible for refunds.

Transfer request to a different dental office will be done only after your account with Dental Care of Walnut Creek is cleared. You have the right to request copies of your x-rays and patient records upon completing a release form; there are no fees assessed for these copies. The original charts/records/x-rays are the properties of Dental Care of Walnut Creek per the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This policy applies to all patients in, but not limited to, the following situations: new patients, existing patients, emergency patients, patients who are eligible one month but not the next due to job change, patients not assigned to the office, and patients who plead ignorance.

General Consent Form

I hereby request and authorize the dentist and the staff at Dental Care of Walnut Creek to perform dental work upon me for the purpose of improving the appearance, function and health of my mouth and its associated structures. I understand it is my responsibility to ask questions prior to any dental procedure. I am aware that I have the right to refuse any procedures to be done in my mouth unless I fully understand what is involved; the risks and benefits of the procedure and its alternatives. I hereby authorize the release of any respective dental records to specialists referred to by Dental Care of Walnut Creek as deemed necessary for the improvement of my oral health. This consent for record release is limited only to referrals made from Dental Care of Walnut Creek, and is not applicable to specialists chosen by the patient outside of the office. Release of records to any dental office(s) not authorized by Dental Care of Walnut Creek will require the completion of a release form.

I know and understand the practice of dentistry and surgery is not an exact science and reputable dental practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance have been made by anyone regarding the dental treatments that I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that only the treating dentist is responsible for my dental treatments.

I acknowledge that I have read a copy of the Notice of Privacy Practice provided to me by Dental Care of Walnut Creek. I understand that a copy of this Notice can be provided upon request.

Notice of Associate Dentists as Independent Contractors

As a valued patient of our office, you will receive care and treatment from "associate" dentists. These associate dentists work in our office as independent contractors, meaning they are individually licensed by the Dental Board of California and are responsible for maintaining their own schedules, continuing dental education, licensing, and policies of professional liability insurance. In short, these associate dentists are not employees of the office, but maintain their own individual professional practices at our office.

As a result, each associate dentist is individually responsible for the care and treatment they provide. If you experience any difficulty or have any questions regarding any care and treatment provided by an associate dentist, please consult with them directly. If you find that the associate dentist has not responded adequately to your inquiries, please inform the office and we will work to assist you in resolving any issues you may have.

Please date and sign below acknowledging your understanding that associate dentists are not employees of our office.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

DENTAL CARE OF WALNUT CREEK

Appointments Cancellation Policy

We understand that unforeseen emergencies do occur, and may take precedence over upholding your appointment If you must cancel your appointment, please do make a simple phone call or email to us, so that we can give your appointment time to our patients on our waiting list. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

As a courtesy to our staff and other patients, please allow a 24 hour notice for cancellations and rescheduling requests.

- No penalty will be assessed for the first time
- Repeat broken appointments may be assessed a minimum fee of $50 per broken appointment (examination appointments, hygiene appointments, emergency appointments, or consultation)
- Broken appointments that require a deposit will result in the forfeiture of that deposit
- Three or more broken appointments may lead to dismissal from Dental Care of Walnut Creek
- We reserve the right to dismiss any patient who cancels their appointment repeatedly.

Thank you for being a valued patient of Dental Care of Walnut Creek and your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all our patients.

I have read and understand the above cancellation policy.

_____

Print Name

_____

Patient or Parent/Guardian Signature

_____

Date