Today's date:____/____/____

Patient Information Form

Patient Name: First_____ MI_____ Last_____

Address: Street_____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell_____

E-mail address_____

By providing your e-mail address you agree to receive ☐ Appointment reminder

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Social Security Number *(complete # needed for dental insurance)* _____ **Date of Birth** _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street_____ City_____ State_____ Zip _____

Sex ☐ Male ☐ Female

Emergency contact person:_____ Relationship_____ Phone _____

Dental Benefit Plan Information

Primary Dental carrier: _____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured _____ Date of Birth _____ ID #_____

Group plan #_____ Patient relationship to Insured_____

Secondary Dental carrier: _____ Phone_____

Address: Street_____ City_____ State_____ Zip_____

Name of Insured _____ Date of Birth _____ ID #_____

Group plan #_____ Patient relationship to Insured_____

For office use only:

*Primary Insurance Annual Maximum*_____ *Deductible*_____ *Eval*_____ *Endo*_____ *BU*_____ *Filling* _____

*Secondary Insurance Annual Maximum*_____ *Deductible*_____ *Eval*_____ *Endo*_____ *BU*_____ *Filling* _____

*Notes*_____

_____

Today's date:____/____/____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment cash, major credit cards, personal checks, Care Credit℠ *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a *Credit for Dental Services Notice*.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.
Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the *patient's responsibility* to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on-time. To maintain the utmost service and care, we do require **48-hour** notice to reschedule an appointment. For less than 48-hour notice and no-show appointments, a fee of $50.00 for consultation and $100 for treatment appointments will be charged. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is late *fifteen minutes* or more arriving to our practice. To reschedule an appointment due to late arrival, a deposit fee of $100.00 may be required.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

❑ **I consent** to receiving **emails** from Solano Endodontic Specialists in regards to my appointments, statements and/or information regarding dental treatment.

❑ **I consent** to receiving **text** messages for appointment reminders.

❑ **I do not consent** to receiving text messages or emails from Solano Endodontic Specialists.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____(*initial*)
I have read the above and agree to the financial and scheduling terms. _____(*initial*)
I hereby acknowledge that a copy of this practice's *Notice of Privacy Practices* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____(*initial*)

Signature _____Date_____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking _____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** _____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____
_____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why _____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) | Date | Signature of Dentist | Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ **Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. Yes / No **Is your general health good?**
   If NO, explain _____
2. Yes / No **Has there been a change in your health within the last year?**
   If YES, explain _____
3. Yes / No **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. Yes / No **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam? _____ **Reason for exam** _____
5. Yes / No **Have you had problems with prior dental treatment?**
   If YES, explain _____
   Date of last dental exam _____ **Name of last treating dentist** _____
6. Yes / No **Are you in pain now?**
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____