Hollister & Solomon Dental

1042 Pacific St, Ste B
San Luis Obispo, CA93401
(805) 543-6963

Welcome to our office! We are pleased that you have chosen us to care for your dental health. Please help us by taking some time to fill out both sides of this form. We promise that all of this information will remain confidential.

DATE: _____

PATIENT INFORMATION

Name: _____
(last) (first) (MI) (Preferred Name)
Home Address: _____
(Street)
_____
(City) (State) (Zip Code)
Home Telephone: _____ Cell Phone: _____

Email: _____ Preferred Method of Contact: _____

Date of Birth: _____ Social Security Number: _____ Sex: _____

Marital Status: _____ Spouse or Domestic Partner's Name: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Patient's Employer: _____ Address: _____

Business Phone: _____ Extension or Department: _____

Whom may we thank for referring you? _____

(if different from above) : BILLING INFORMATION

Name of Responsible Party: _____ Phone: _____

Responsible Party's Address (if different from above):_____
(Street)
_____
(City) (State) (Zip Code)
Social Security Number: _____ Date of Birth: _____

Responsible Party's Employer: _____Phone: _____

Employer's Address: _____

(over)

INSURANCE INFORMATION

As a courtesy, we will accept payment of benefits directly from your insurance company. Please fill this part out accurately and completely. The part of our fee that is not covered by your insurance company is due at the time of treatment.

Name of Primary Insurance Company: _____

Name of Employer: _____

Name of Subscriber: _____ Date of Birth: _____

Social Security Number: _____ ID or Policy #: _____

Group Number: _____ Telephone # of Insurance Co: _____

Name of Secondary Insurance Company: _____

Name of Employer: _____

Name of Subscriber: _____ Date of Birth: _____

Social Security Number: _____ ID or Policy #: _____

Group Number: _____ Telephone # of Insurance Co: _____

DENTAL INFORMATION

Reason for today's visit_____

Last dental exam_____ Times a day you brush_____ Times a week you floss_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth?_____
Are you nervous about being at the dentist? _____ Have you ever had a bad experience at the dentist?____

Please indicate any of the following problems by checking the corresponding box:

- o Gums bleed when you brush or floss
- o Discomfort, clicking, or popping in jaw
- o Difficulty opening or closing jaw
- o Red, swollen, or bleeding gums
- o Blisters/sores in or around the mouth
- o Dentures or partial (removable appliance)
- o Teeth grinding or clenching
- o Ringing in the ears
- o Bad breath
- o Dry mouth
- o Food caught between teeth
- o Toothache
- o Swelling/lumps in the mouth
- o Sensitivity to hot, cold, sweets, biting
- o Have had periodontal (gum) treatments
- o Have had orthodontic treatment

MEDICAL INFORMATION

Are you under the care of a physician? If so, physician's name_____

Physician's phone number_____ Location_____

Are you in good health?_____ Has there been a change in your health in the past year?_____
If yes, please describe condition and treatment_____

Date of last physical exam_____ Have you had a serious illness or hospitalization in the past 5 years?_____ If yes, what was the illness or problem?_____

Are you taking or have recently taken any prescription or over the counter medicine(s)_____
If yes, please list all, including vitamins, natural or herbal preparations, and/or diet supplements:

_____ _____ _____

_____ _____ _____

Are you allergic to or have you had a reaction to any medications, metals, or materials (penicillin, latex, iodine, local anesthetics)? _____ If yes, please list_____

Have you had an orthopedic total joint replacement?_____ If yes, date and procedure_____

Are you taking or scheduled to begin taking blood thinners (Plavix, Warfarin, Coumadin)? _____

Do you use tobacco products? _____ If yes, how often per day?_____

Do you drink alcoholic beverages? _____

WOMEN ONLY: Are you pregnant? ____ If yes, how many weeks? _____
Are you taking birth control pills or hormone replacement? _____

Please indicate any of the following problems you have or have had with a check mark next to the condition:

Cardiovascular disease	Neurological Disorder	Diabetes Type I or Type II
Arteriosclerosis	Mental Health Disorder	Kidney Problems
Heart Attack	Fainting Spells or Seizure	HIV or AIDS
Artificial Heart Valve	Epilepsy	Anemia
Mitral Valve Prolapse	Severe Headaches	Blood Disorder
Congenital Heart Disease	Sleep Disorder	Autoimmune Disease
Previous Infective Endocarditis	Emphysema	Rheumatoid Arthritis
Congestive Heart Failure	Asthma	Arthritis
High Blood Pressure	Bronchitis	Sinus Trouble
Low Blood Pressure	Gastrointestinal Disease	Osteoporosis
Pacemaker	Acid Reflux, Persistent Heartburn	Lupus
Stroke	Ulcers	Hepatitis, Jaundice, or liver Disease
Angina	Malnutrition	Tuberculosis
Abnormal Bleeding	Eating Disorder	Thyroid Problems
Other Heart Condition or Defect	Chronic Pain	Cancer/Chemotherapy/Radiation

Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment?___
Name of physician or dentist that made the recommendation_____ Phone_____

(over)

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on the previous pages is accurate to the best of my knowledge. I understand the importance of a truthful health history and that my dentist and/or his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

X_____ Date_____
Signature of patient (Parent or Guardian, if Minor)

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this sheet.
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** If you fail to pay, you will be responsible for all collection costs, attorney fees, and court costs.

X_____ X_____
Signature of patient (Parent or Guardian, if Minor) **Date**

This signature on file is my authorization for the release of information to process my insurance claim. I hereby authorize payment to this doctor/office named of the benefits otherwise payable to me.

X_____ X_____
Signature of patient (Parent or Guardian, if Minor) **Date**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area of Hollister and Solomon Dental. I further acknowledge that I will be given a copy if requested.

X_____ X_____
Signature of patient (Parent or Guardian, if Minor) **Date**