PATIENT INFORMATION

(This information is necessary for our files and will be considered *confidential*)

Patient's Name: ______________________________ Age: ______ Date of Birth: ____/____/____
Last Name First Name Middle Initial
If patient is a Minor, full name of Parent or Legal Guardian: ______________________ Relationship: ____________
Patient's Home Address: ______________________________ Own [ ] Rent [ ] How long? ________

Patient's Status: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed
Patient's Driver's License No.: ___ ___ ___ ___ ___ ___ ___ ___ Patient's Social Security No.: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Patient's Home Phone No.: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Patient's Cell Phone No.: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Patient's E-mail Address: ______________________________
Patient's Employer: ______________________ Occupation: ______________ How long? ________
Patient's Business Address: ______________________ Work Phone No: (____) ___ ___ ___ - ___ ___ ___ ___
Spouse's Name: ____________ Spouse's Driver's License No.: ____________ Spouse's Social Security No.: ____________
Spouse's Employer: ______________________ Occupation: ______________ How long? ________
Spouse's Business Address: ______________ Work Phone No.: ____________ Cell Phone No.: ____________
Name of Nearest Relative Not Living with You: ______________________ Relationship: ____________
Relative's Address: ______________________ Phone No.: ____________
Name of Primary Care Physician: ______________________ Phone No.: ____________
Address of Physician: ______________________________
Name of Former Dentist: ______________________________
Address of Former Dentist: ______________________________
Purpose of This Appointment: ______________________________
Is this an Emergency Visit? Yes [ ] No [ ] if yes, explain: ______________________________
Whom May We Thank for Referring You? ______________________________
Address: ______________________ Phone No.: ____________
School(s) Children Attend: ______________________________

FINANCIAL INFORMATION

In an effort to provide you with quality dental work and flexible payment arrangements, we provide the list below.
Please select one option.
Please know that treatment will not be initiated unless patient commits to a payment option.
We do not perform any treatment based on the assumption that insurance will pay for our services.
Patient is responsible for all services we perform.

PAYMENT ARRANGEMENTS ARE REQUIRED AT THE TIME OF FIRST VISIT

Person Responsible for This Account: ______________________________
Address: ______________________________
Relationship to Patient: ____________ Home Phone No.: ____________ Cell Phone No.: ____________

Option A: [ ] Payment in Full by Cash or Check on each visit
Option B: [ ] Payment in Full by Credit Card (VISA or MASTERCARD only)
Credit Card No.: ________ ________ ________ ________ Expiration Date: ______/______

INSURANCE INFORMATION

Name of Insurance Company (Primary): ______________________________
Address: ______________________________
ID No.: ____________ Group No: ____________ Phone No: ____________
Name of Insurance Company (Secondary): ______________________________
Address: ______________________________
ID No.: ____________ Group No: ____________ Phone No: ____________

TERMS AND CONDITIONS

As a condition of treatment in this office, I understand that financial arrangements must be made in advance or on the day of the treatment prior to the start of the dental work. All emergency services and those without prior financial arrangements must be paid in cash before services are performed. I understand and agree that I am responsible for all services furnished to me. I understand that this office will not render services in the assumption that all services will be covered by dental insurance. I accept full responsibility and agree to pay whatever amount the insurance will not cover. I hereby authorize the insurance company to pay directly to the dentist benefits accrued to me under my insurance policy. ***I agree to pay a one and one-half percent (1 1/2%) service charge on all unpaid balances not paid within 15 days of treatment date.*** I agree that a waiver for any breach of any of the terms or conditions herein shall not constitute a waiver for any further terms or condition. In the event of legal proceedings with respect to any amount owed by me for services rendered, the prevailing party shall be entitled to recover all costs including attorney's fees. I grant permission to call me at work, home or my cell phone to discuss matters related to this form. ***Except in cases of extreme emergencies, I understand that this office reserves the right to charge me for "broken appointments" without 24 hours notice.*** I hereby grant Dr. de la Vega the rights to use photos and images of my dental work for educational and other purposes associated with his work. I agree with the contents of the above Terms and Conditions.

Signature: ______________________________ Today's Date: ______/______/______

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral care. Please answer each question to the best of your knowledge.

MEDICAL HISTORY

Check YES or NO where applicable.

1. Are you in good health? [ ] Yes [ ] No
2. Are you under the care of a physician? [ ] Yes [ ] No
   If Yes, what is the condition being treated? ____________
   Date of last physician visit: ____________
3. Have you ever been hospitalized? [ ] Yes [ ] No
   If Yes, please explain: ____________
4. Have you ever had any serious illnesses or operations? [ ] Yes [ ] No
   If Yes, please explain: ____________
5. Have you had any heart surgery? [ ] Yes [ ] No
6. Do you wear a cardiac pacemaker? [ ] Yes [ ] No
7. Are you taking any medications? [ ] Yes [ ] No
   If Yes, please list: ____________
8. Do you use any recreational drugs? (marijuana, cocaine, etc.) [ ] Yes [ ] No
9. Do you use any herbal diet supplements? (i.e., ginko bilova) [ ] Yes [ ] No
10. Do you take any diet pills? (Phen-fen, etc.) [ ] Yes [ ] No
11. Are you sensitive or allergic to any drugs? [ ] Yes [ ] No
    [ ] Penicillin [ ] Tetracycline [ ] Sulfas
    [ ] Aspirin [ ] Codeine [ ] LATEX
    [ ] Other: ____________
12. Do you smoke? [ ] Yes [ ] No
    If Yes, how often? ________ / day

FOR WOMEN:

1. Are you pregnant? [ ] Yes [ ] No
   If Yes, how many weeks or months? ________
2. Do you have problems associated with your menstruation? [ ] Yes [ ] No
3. Do you take birth control pills? [ ] Yes [ ] No

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

Circle YES or NO where applicable.

(Yes) (No) Acquired Immune Deficiency Syndrome (AIDS)
(Yes) (No) AIDS Related Complex
(Yes) (No) Allergies or Hives
Explain: ____________
(Yes) (No) Anemia
(Yes) (No) Angina
(Yes) (No) Arthritis
(Yes) (No) Artificial Prosthesis
(Yes) (No) Asthma
(Yes) (No) Bleeding
(Yes) (No) Blood Disease
(Yes) (No) Blood Transfusion
When: ________
(Yes) (No) Cerebral Palsy
(Yes) (No) Chemotherapy (Cancer, Leukemia, etc.)
(Yes) (No) Chicken Pox
When: ________
(Yes) (No) Cobalt Therapy
(Yes) (No) Cold Sores
(Yes) (No) Congenital Heart Lesions
(Yes) (No) Cortisone Therapy
(Yes) (No) Diabetes
(Yes) (No) Difficulty in Swallowing
(Yes) (No) Drug Addiction
(Yes) (No) Emphysema
(Yes) (No) Epilepsy or Seizures
(Yes) (No) Fainting Spells
(Yes) (No) Glaucoma
(Yes) (No) Hay Fever
(Yes) (No) Heart Ailments or Attacks
(Yes) (No) Heart Failure
(Yes) (No) Heart Murmur
(Yes) (No) Hemophilia
(Yes) (No) Hepatitis or Jaundice
(Yes) (No) Herpes
(Yes) (No) High Blood Pressure
Last Reading: ___ / ___
(Yes) (No) Joint Replacement
(Yes) (No) Kidney Disease
(Yes) (No) Liver Disease
(Yes) (No) Mental Disorder
(Yes) (No) Nervous Disorder
(Yes) (No) Pain in Jaw Joints
(Yes) (No) Psychiatric Treatment
(Yes) (No) Rheumatism
(Yes) (No) Scarlet Fever
(Yes) (No) Sickle Cell Anemia
(Yes) (No) Sinus Trouble
(Yes) (No) Stomach Ulcers
(Yes) (No) Stroke
(Yes) (No) Thyroid Disease
(Yes) (No) TMJ Disorder (Temporomandibular Joint)
(Yes) (No) Tonsillitis
(Yes) (No) Tuberculosis (TB)
(Yes) (No) Tumor or Growth
(Yes) (No) Ulcers
(Yes) (No) Venereal Disease (Syphilis, Gonorrhea, etc.)
(Yes) (No) X-Ray or Radiation Treatment
(Yes) (No) Other: ________

DENTAL HISTORY

Check YES or NO where applicable.

1. Have you ever had local anesthesia? (Novocaine, Lidocaine, etc.) [ ] Yes [ ] No
2. Have you ever had any unfavorable reaction(s) from a local anesthetic? [ ] Yes [ ] No
   If Yes, please explain: ____________
3. Have you ever been pre-medicated with antibiotics for your dental work? [ ] Yes [ ] No
4. Have you had any serious trouble associated with any previous dental treatment(s)? [ ] Yes [ ] No
5. How long since your last full mouth x-ray? ____________
6. How long since your last dental treatment? ____________
7. Does dental treatment make you nervous? [ ] Yes [ ] No
   If Yes, please circle one: (slightly) (moderately) (extremely)
8. Would you desire to be pre-sedated? [ ] Yes [ ] No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health status or if my medications change, I will, without fail, inform the front desk clerks and/or the doctor at my next appointment.

Date: ____/____/____ Signature: ____________

Year 2: *Changes in health*: ____________
Date: ____/____/____ Signature: ____________
Year 3: *Changes in health*: ____________
Date: ____/____/____ Signature: ____________

*** HEALTH QUESTIONNAIRE MUST BE UPDATED EVERY YEAR! ***

Reviwed By:	DO NOT WRITE IN THIS SPACE		
	Year 1	Year 2	Year 3
Year 1	Date	Date	Date
	BP	BP	BP
Year 2	Pulse	Pulse	Pulse
	Temp.	Temp.	Temp.
Year 3	Resp.	Resp.	Resp.
	By:	By:	By:

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the patient whose name and/or signature appears on this Health Questionnaire form, to administer such anesthetics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signature: ____________ Today's Date: ____/____/____

Note: In the case of a Minor, or when the patient is physically or mentally incompetent, authorization **must** be signed by a parent or legal guardian.
Relationship to the Patient: ____________