EMERALD VALLEY
DENTAL

CONFIDENTIAL PATIENT INFORMATION

Name: ______ Social Security: ______ Date: ______ Birthday: ______ Gender:(M / F)

Mailing Address: ______

City: ______ State: ______ Zip: ______ Preferred Phone: ______

Cell: ______ Work: ______ Email: ______

Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Number of Children in Household (per age group): ______ 0–23 months ______ 24 months–5 years ______ 6–15 years ______ 16 years & older

Patient's or Parent's Employer: ______ Work Phone: ______

Spouse or Parent's Name: ______ Employer: ______ Work Phone: ______

Whom May We Thank for Referring You? ______

Person to Contact in Case of Emergency: ______ Relationship to Patient: ______ Phone: ______

RESPONSIBLE PARTY

Name of Person Responsible for this Account: ______ Relationship to Patient: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Birthday: ______ Driver's License # ______ Social Security: ______

Employer: ______ Work Phone: ______

INSURANCE INFORMATION

Name of Insured: ______ Relationship to Patient: ______ Birthday: ______ Social Security: ______

Employer: ______ Date Employed: ______ Work Phone: ______

Address of Employer: ______ City: ______ State: ______ Zip: ______

Insurance Company: ______ Group # ______ Policy/ID # ______

Insurance Company Address: ______ City: ______ State: ______ Zip: ______

Do you have additional insurance? If yes, please complete the section below.

Name of Insured: ______ Relationship to Patient: ______ Birthday: ______ Social Security: ______

Employer: ______ Date Employed: ______ Work Phone: ______

Address of Employer: ______ City: ______ State: ______ Zip: ______

Insurance Company: ______ Group # ______ Policy/ID # ______

Insurance Company Address: ______ City: ______ State: ______ Zip: ______

NOTICE OF PRIVACY PRACTICE

I have received a copy of this office's Notice of Privacy Practice.

Print Name: ______ Signature: ______ Date: ______

FOR OFFICE USE ONLY:
We attempted written acknowledgement of receipt of our Notice of Privacy Practice but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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For Office Use Only:

Reviewed By: ____________ Update: ____________ Update: ____________
Update: ____________ Update: ____________ Update: ____________
Update: ____________ Update: ____________ Update: ____________

Physician: ____________ Office Phone: ____________ Blood Pressure ____________

PATIENT MEDICAL HISTORY

	Yes	No
1. Are you under medical treatment now? If yes, please explain: ____________	☐	☐
2. Have you been hospitalized for any surgical operation or serious illness within the last year? If yes, please explain: ____________	☐	☐

3. Do you have any allergies or are you allergic to any medications?

____

4. Are you taking any medication(s) or drugs?
If yes, list medication, condition treated, and how often taken:

____

	Yes	No
5. Are you currently taking any bone enhancing drugs? (Ex: Fosamax, Boniva)	☐	☐

____

		Yes	No
6. Do you use tobacco?		☐	☐
If yes, type of tobacco user:	Cigarette	☐	☐
	Cigar/Pipe	☐	☐
	SmokeLess tobacco	☐	☐
How frequently:	Less than a pack/day	☐	☐
	Pack a day	☐	☐
	More than a pack/day	☐	☐

7. Please complete the following:

	Yes	No
Heart Attack	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Joint Replacement or Implant	☐	☐
Mitral Valve Prolapse	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Cardiac Pacemaker	☐	☐
Diabetes	☐	☐
Angina	☐	☐
Fainting/Seizures	☐	☐
Epilepsy/Convulsions	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Leukemia	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Liver Disease	☐	☐
Hepatitis - please circle: A B C	☐	☐
Ulcers	☐	☐
Kidney Disease	☐	☐
AIDS or HIV infection	☐	☐
Thyroid Problem	☐	☐
Psychiatric Condition	☐	☐
Hemophilia/Bleeding Disorders	☐	☐
Other ____________		

8. Women Only:

	Yes	No
a) Are you pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

PATIENT DENTAL HISTORY

1. Please list reason for visit today: ____________

2. State long term dental goals: ____________

3. Name of previous Dentist and Location: ____________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Do you have any sores or lumps in or near your mouth?	☐	☐
3. Have you had any head, neck or jaw injuries?	☐	☐
4. Do you clinch or grind your teeth?	☐	☐
5. Have you ever had any prolonged bleeding following extractions?	☐	☐
6. Have you had any orthodontic treatment? If yes, date of placement:	☐	☐
7. Are you interested in improving your smile (whiter teeth)?	☐	☐
8. Have you ever had a reaction to local anesthetic?	☐	☐
9. Have you ever had scaling or root planning (deeper cleaning)?	☐	☐
10. Do you currently have partial denture/dentures or implants?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent if Minor): ____________ Date: ____________

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DENTAL

CONSENT TO DENTAL PROCEDURES, ADMINISTRATION OF ANESTHETICS, SEDATIVES AND THE RENDERING OF OTHER SERVICES.

Patient: ____ Age: _________ Date: _____________

1. I hereby authorize Dr. Bahen and/or such assistants as may be selected, to perform Routine Dental Care upon the above named and/or any other therapeutic procedure that his/her/their judgement may dictate to be advisable for the patient's well-being.

2. The nature and purpose of the procedure and anesthetic, the risks involved, and the possibility of complications has been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia and sedation have been explained to me and I authorize the administration of such anesthesia and sedation as may be considered necessary or desirable.

3. I authorize that any specimens, tissue or parts removed from the patient may be disposed of in accordance with established practice.

4. I further authorize the performance by any qualified person of any other services which are deemed to be necessary or advisable.

5. If in Dr. Bahen's opinion, further observation of the above named is indicated after an anesthetic or procedure, the above named agrees to be transported by ambulance at his/her personal expense to a mutually satisfactory hospital in the local area, and to be admitted for observation and any necessary treatment.

6. If in Dr. Bahen's opinion, the above named requires the services of a specialist, he/she agrees to accept the referral and will be responsible for any expense that may be incurred.

7. I certify that I have read this Consent, or that it has been read to me, and that I understand the above. The nature and purpose of such operation(s), procedure(s), treatment(s), and/or services and the reasons why the same is (are) considered necessary or advisable has been explained to me.

Signature of Patient (Or Person Authorized To Sign For Patient)

_________________________________ _________________________________

Relationship to patient: ____________________

EMERALD VALLEY
DENTAL

EMERALD VALLEY DENTAL
PAYMENT POLICY

Cash | Check | Visa | Mastercard | Discover
Payment is due at time of treatment.

DENTAL INSURANCE
Payment of your percentage of insurance coverage is due at the time of treatment. As a courtesy to our patients, we will bill your insurance. However, if there is no payment from your Insurance Company to our office within 60 days, or payment is lower than the total bill, you will be responsible for the balance in full at that time. We are not able to negotiate with your Insurance Company on your behalf.

PAYMENT PLANS
Emerald Valley Dental offers affordable payment plans through an outside lending agency.
Applications are available at the front desk and status of approval can be obtained within fifteen minutes.

As a patient, or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office, as stated above. There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to Finance Charges of 1.5% of the unpaid balance which is an Annual Percentage Rate (APR) of 18%. I (we) hereby authorize Emerald Valley Dental to furnish my (our) Insurance Company (Companies) all information required concerning my (our) dental care.
I hereby assign to Emerald Valley Dental all payments to which I may be entitled for dental expenses, and do hereby direct that payment for such expenses be paid directly to Emerald Valley Dental.

Signature of Patient or Legal Guardian: Date: ____________________

____

Please indicate how you wish to pay for your dental treatment:

Cash: ________ Check: ________ Credit Card: ________ Other: ________