Tamal Vista Family Dentistry

1447 Fourth St.
San Rafael, CA, 94901
(415)453-4720
(415)453-4727 (fax)

Welcome to our office! We aim to make your visit pleasant and comfortable ~ Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET

_____
CITY STATE ZIP

Employer _____ Occupation _____

E-mail _____ Birth date _____

Phone: Home _____ Social Security # _____

Work _____

Cell _____ ❑ Male ❑ Female

Emergency: Name _____ Phone _____

Insurance - * Please provide card to receptionist *

Primary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Treatment and Payment Authorization Statement (Sign & Date)

I understand that I am fully responsible for all costs of dental treatment. I hereby authorize my doctor to act as my agent and release all necessary information required by my insurance carrier and for all insurance payment to directly go to the doctor. I hereby authorize the doctor to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes.

Signature _____ Date _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET

_____
CITY STATE ZIP

School _____ If pt under 24 and full time in school – name of school _____

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

_____

Medical and Dental Information

Last Physical Exam_____ Physician's Name & Phone # _____

Last Dental Visit _____ Dentist's Name & Phone # _____

Have you ever responded adversely to dental treatment? ---------- Yes ( ) No ( )

Are you taking Aspirin or any other type of anticoagulant (blood thinner)? ---------- Yes ( ) No ( )

Have you ever taken **Fen-Phen** or other prescription weight loss medications? ---------- Yes ( ) No ( )

Have you ever taken bone loss prevention medication such as **Fosamax**, Actonel, Bonivia or similar? ------ Yes ( ) No ( )

Have you taken any steroid/cortisone therapy in the last 2 years? ---------- Yes ( ) No ( )

Have you ever had a transplant, artificial joint or heart valve surgery? If so, when? _____ Yes ( ) No ( )

Have you ever had a reaction to penicillin, aspirin, codeine, anesthetics, **latex**, metals or other medication? - Yes ( ) No ( )

List any medications you're allergic to: _____

List any medications you're currently taking (include herbals and vitamins)

_____

_____

Do you have a history of:	YES	NO		YES	NO		YES	NO
Rheumatic Fever	( )	( )	Venereal Disease	( )	( )	Sinus Problems	( )	( )
Heart Murmur	( )	( )	HIV+/AIDS	( )	( )	Cancer (Type:)	( )	( )
Mitral Valve Prolapse	( )	( )	Blood transfusion	( )	( )	Chemotherapy	( )	( )
Heart Problems	( )	( )	Excessive Bleeding	( )	( )	Radiation Treatment	( )	( )
Pace Maker	( )	( )	Anemia	( )	( )	Tobacco Use	( )	( )
High Blood Pressure	( )	( )	Hepatitis (Type)	( )	( )	Drug Addiction	( )	( )
Low Blood Pressure	( )	( )	Liver Disease	( )	( )	Alcoholism	( )	( )
Diabetes	( )	( )	Kidney Disease	( )	( )	Psychiatric Care	( )	( )
Stroke	( )	( )	Dialysis	( )	( )	Mouth sores/growths	( )	( )
Lung Disease	( )	( )	Thyroid Disease	( )	( )	Teeth Grinding/Clenching	( )	( )
Breathing Problems	( )	( )	Epilepsy or Seizures	( )	( )	Pain in jaw joint (TMJ)	( )	( )
Tuberculosis (TB)	( )	( )	Fainting or Dizzy Spells	( )	( )	Surgical Implant	( )	( )
Asthma	( )	( )	Stomach Ulcer	( )	( )	Transplant Surgery	( )	( )
Emphysema	( )	( )	Arthritis	( )	( )	Any Artificial Joint	( )	( )
Allergies or Hives	( )	( )	Difficulty lying on back	( )	( )	Dental Anxiety	( )	( )

Other Medical information or impending treatment that could affect your dental care: _____

_____

Women : Are you pregnant? Yes ( ) No ( ) Estimated due date: _____

Are you nursing? Yes ( ) No ( ) Are you on birth control meds? Yes ( ) No ( )

I certify that I have answered the above questions to the best of my knowledge and shall advise the doctor of any future changes.

_____

Patient's Signature Date

Dental Health Questionnaire

In understanding your dental needs and wants, we can provide you with the most attentive and complete dental care. Please complete the following:

***Thanks* – Dr. McDowell and Dr. Scott**

Last dental exam and preventive cleaning. _____

Do you smoke? If so, how many packs a day, how long? _____

If wearing dentures, age of dentures _____

If playing sports, do you need a mouth guard? _____

Have you had braces (orthodontic treatment) before? _____

Have you had your wisdom teeth extracted? _____

What major dental treatment have you gone through? _____

Are you interested in,(please "X")

- ❑ A sleep apnea or snoring appliance
- ❑ Cosmetic Treatment (Invisalign, Veneers, etc).
- ❑ Protective sealants to prevent cavities
- ❑ Custom fit mouthguards for sports or grinding
- ❑ Teeth Whitening treatment.
- ❑ Dental implants.
- ❑ Replacing metal fillings with tooth colored restorations

Do you ever grind or clench your teeth? _____

Are your teeth ever sensitive to temperature? _____

Do you know if the water you drink is fluoridated? _____

Is it important to you to have fluoride in drinking water? _____

What type of toothpaste and toothbrush do you use? _____

What have you liked the most at your past dental appointments?

_____

What negative experiences have you had at the dental office before?

_____

If there is something you could do to change your smile, what would it be?

_____

_____

_____

_____

Patient Acknowledgement and Signatures

_____ ***Consent for Care and Treatment***

I, the undersigned, hereby agree and give my consent for ***Tamal Vista Family Dentistry*** to furnish care and treatment considered necessary and proper in treating my condition.

_____ ***Authorization for Signature on File and Release of Information***

I, the undersigned, hereby agree and give my consent for ***Tamal Vista Family Dentistry*** to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorized the release of any information relating to my health care claims. A photo stated copy of this authorization shall be as valid as an original.

_____ ***Authorization for Assignment of Benefits***

I, the undersigned, hereby assign all insurance benefits, to which I am entitled, to ***Tamal Vista Family Dentistry***, and I shall be financially responsible for any unpaid balance. In the event payment is made directly me for serviced rendered by this office, I recognize the obligation to promptly remit payment to ***Tamal Vista Family Dentistry***. I hereby authorize and instruct my insurance company to pay by check and mail directly to ***Tamal Vista Family Dentistry.***

_____ ***Financial Responsibility***

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsibility for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. Should my balance extend beyond 90 days with no attempt to may payment, I understand that my balance will be subject to a finance charge 1.5%, for which I am financially responsible.

_____ ***Cancellation Guidelines***

We have reserved a specific time for you with our providers. If you cannot keep your scheduled appointment, please be sure to notify us within two business days, so that we may offer your reserved time to another patient. If we are not given ample notification for a cancellation or you do not make it your appointment, you are subject to a $75 fee for preventative appointments and $150 fee for doctor's restorative appointments. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

_____ ***Reminder Message***

I, the undersigned, hereby authorize ***Tamal Vista Family Dentistry*** to send reminders to my (please "X" preferences) _____ Email _____ Preferred Phone

_____ ***HIPPA***

I, the undersigned, understand that my patient data and privacy rights are outlined on a HIPPA disclosure document found on our company website – www.tamalvistadental.com

I have read & fully understand the above information, and hereby agree to comply as outlined:

_____

Patient Signature Date