Carmel Valley Dental

Welcome to Our Practice

Our mission is to help patients achieve a high level of dental health, which in turn improves the quality of their lives. We do this by our commitment and dedication to SERVICE, EDUCATION, ATTITUDE, and TEAM WORK.

PATIENT INFORMATION

Mr. Mrs. Dr. Ms. Miss Rev. I wish to be addressed as: _____ Date _____

Patient Name _____ Date of Birth _____ Age _____

Address _____ City,State,Zip _____

Home Phone _____ Cell _____ Work _____

Email _____ SS# _____ Marital Status _____

Employer _____ If Student, Name / City of School _____ FT PT

Spouse Name _____ Date of Birth _____

RESPONSIBLE PARTY

Responsible Party _____ Relationship _____

Address _____ City, State, Zip _____
(If different from above)

Home Phone _____ Cell _____ Work _____

SS# _____ Date of Birth _____ Employer _____ Ins Y N

DENTAL INSURANCE INFORMATION

Primary Insurance _____ Phone _____ Grp # _____

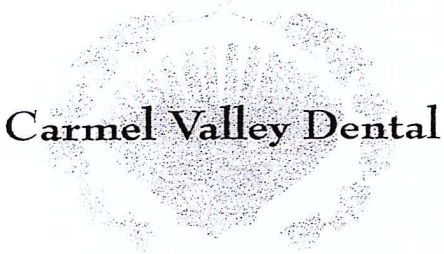
Subscriber _____ SS / ID _____ Birthdate _____

Secondary Insurance _____ Phone _____ Grp # _____

Subscriber _____ SS / ID _____ Birthdate _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you ? _____



Informed Consent, Authorization

The Information that I have given today is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Carmel Valley Dental of any changes to my medical status, address, phone numbers, email, and insurance carriers.

I authorize the Carmel Valley Dental clinical staff to perform any necessary dental services, such as x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I further authorize Dr. Lindsay Bancroft, the Hygienists, and the Dental Assistants to perform any and all forms of treatment and administer medication and therapy allowed within their license parameters.

I understand that I will be presented with a treatment estimate prior to any previously diagnosed treatments are performed. I understand that I am responsible for payment of all services rendered regardless of insurance coverage. I am aware that my insurance may pay less than estimated and in that event I am responsible for all balances due. I am also aware that all payments are due on the day services are rendered. If other arrangements are necessary I must have a signed financial agreement in my record.
_____ (Initials)

I understand that Carmel Valley Dental requires 48 business hours / 2 business days notice (not including Saturdays and Sundays) for any cancelations or changes in your appointment. A charge of $50 per appointment may be placed. (Office determination)
_____ (Initials)

I acknowledge I have received, or have read Carmel Valley Dental's copy of the Dental Materials Fact Sheet dated May 2004 and the Hipaa notice or privacy act.

I authorize all employees and doctors of Carmel Valley Dental to release any information including any treatment rendered for my dependents or myself to third party payers and/or health practitioners. I acknowledge that I am over 18 years old.

_____ _____

Patient / Responsible Party Name (Printed) **Signature**

_____

Date

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

This policy is to inform you of your financial obligation to **Carmel Valley Dental**

- All payment for services rendered are due and payable on the date of service. Carmel Valley Dental accepts the following methods of payment: cash, checks, debit cards, American Express, Discover, MasterCard, Visa, and CareCredit.

- As a courtesy to our patient's with insurance and in an effort to save you time, we are happy to complete and submit claims on your behalf. By having our office submit your claims it is important that you understand that this does not eliminate your financial obligation for treatments performed. In order for our office to submit your claims, it is your responsibility to provide the current dental insurance information in the form of an ID card at each visit. If the subscriber is someone other than you we require in advance, their date of birth, ID or Social Security Number, as well as the insurance company information in order to verify the coverage effective date and benefits.

- Carmel Valley Dental does not guarantee that your insurance company will pay for treatments you receive. Prior authorizations received are not a guarantee of payment. It is your responsibility to know all eligibility dates, and limitations including frequencies prior to scheduling your appointments. In the event your claims deny you are ultimately responsible. Carmel Valley Dental abides by American Dental Association guidelines and will not compromise our patients care to satisfy insurance requirements.

- Insurance payments are generally received within 30 days from the time of billing. In the event the insurance company has not paid at the end of the 30 day period you will be required to pay the entire balance. You will be responsible to seek any reimbursement from your insurance for claims older than 60 days. Carmel Valley Dental will provide any necessary documentation your insurance company requests in order to help answer questions that arise.

- I hereby authorize my insurance company to pay Carmel Valley Dental, Dr. Lindsay Bancroft, DDS and associates all benefits due me by reason of services described in the statements rendered and the above policy contract. I understand that I am financially responsible for charges not covered by this authorization.

- In the event of a returned check you will be subject to collection fees and possible finance charges at the rate of 1.5% per month.

By signing this agreement I am acknowledging that I am over 18 and I am assuming financial responsibility for myself or _____ for all dental charges performed by
Patient Name
Carmel Valley Dental, Lindsay Bancroft, DDS and Associates regardless of any dental insurance coverage. I also acknowledge that I have read and agree to the above financial policy and insurance assignment.

_____	_____	_____
Date	Signature of Patient or Responsible Party	Relationship to Patient

Health History Form

American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*

Home Phone: *Include area code* ( )

Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*

City: State: Zip:

Occupation:

Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact:

Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

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 this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her 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/her 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.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: