PARMER OAKS DENTAL CARE

Today's Date_____

Name_____ **H**ome Phone ( ) -
Address_____ **W**ork Phone ( ) -
City_____ **S**tate_____ **Z**ip_____ **C**ell Phone ( ) -
Employer_____ **E**-mail_____
SS#_____ **D**ate of Birth____/____/_____ **G**ender M/F **H**eight_____
Weight_____ **M**arital Status _____ **S**pouse Name_____
Closest Relative_____ **P**hone ( ) - **R**eferral Source_____
In your absence can we leave a message on answering machine or individual who answers? Y__ N__

Please check "Yes" or "No" to the following questions. Your records are considered confidential and for our use only. Additional questions may be asked of you regarding your health questionnaire during your visit.

Medical

1. Date of last physical exam_____ Are you now under the care of a Physician? …….. **Y__ N___**
2. Physician's Name_____
3. History of serious illness, operation or hospitalization within past 5 years? …… **Y__ N___**
   If so, explain reason _____
4. Drugs, medications or pills being taken: _____, _____, _____, _____, _____, _____ ,_____**Y__ N___**
5. Do you dip or smoke tobacco? …… **Y__ N___**
6. Do you have or have you had any of the following diseases or conditions?
   a. Rheumatic fever, rheumatic heart disease, MVP, heart murmur ……. **Y__N___**
   b. Artificial or replacement heart valves or cardiac pacemaker …….. **Y__N___**
   c. Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, HBP, arteriosclerosis, stroke, congenital heart defects)……..……**Y__ N___**

	Y	**N**		**Y**	**N**
d. Allergy or sinus problem	___	___	q. Fainting spells or seizures	___	___
e. Thyroid problems	___	___	r. Epilepsy or other neurological disease	___	___
f. Asthma or hay fever	___	___	s. Arthritis or Inflammatory rheumatism	___	___
h. TB, persistent cough, bloody coug	___	___	t. Persistent swollen glands in neck	___	___
i. Artificial or replacement joints	___	___	u. Low blood pressure	___	___
j. AIDS or HIV	___	___	**v.** Cancer	___	___
k. Problems of the immune system	___	___	w. Mental health issues	___	___
l. Hepatitis, jaundice or liver disease	___	___	x. Sexually transmitted disease	___	___
m. Diabetes	___	___	y. Blood disorder (anemia, hemophilia)	___	___
n. Persistent diarrhea or weight loss	___	___	z. Radiation therapy	___	___
o. Stomach ulcer or hyperacidity	___	___	aa. Abnormal bleeding	___	___
p. Kidney problem	___	___	bb. Blood transfusion	___	___

7. Are you allergic or have you had a reaction to:

a. Local anesthetics	___ ___	e. Iodine	___ ___
b. Penicillin or antibiotics	___ ___	f. Codeine or narcotics	___ ___
c. Barbiturates,sedatives,sleeping pills	___ ___	g. Other:	___ ___

8. List any disease, condition or problem not listed above that you think I should know about:

_____

_____

Dental

1. Reason for your visit _____
2. Have you ever had serious trouble associated with a prior dental treatment?

   Yes___ No___ If so, please explain_____
3. Does dental treatment make you nervous? **No___ Slightly___ Moderately___ Extremely___**
4. Are you having discomfort at this time? **Yes___ No___**
5. Do you have sensitivity in your teeth due to: **Hot__ Cold__ Sweets___ Pressure___**
6. Do you have bad breath? **Yes___ No___**
7. Do your gums bleed when chewing, brushing or any other time? **Yes___ No___**
8. History of, or current jaw joint pain, muscle spasm, or inability to fully open or close your mouth? **Yes___ No___**
9. Do you clench your teeth during the day or been made aware or grinding your teeth during the night? **Yes___ No____**
10. Previous dentist's name, City, State_____
11. Date of last dental exam and cleaning_____

Women: Are your pregnant or nursing? **Yes___ No___**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

I give permission for my dentist and the clinical staff to take any necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment.

In addition, I grant permission for you or your assignee call me at home or work to discuss matters related to this form.

Patient/Guarantor Signature_____ date_____

Parent/Guardian (if under 18 years of age)_____ date _____

Dentist Signature_____ date_____

Next visit:_____ recare: _____6 mo____ 4 mo_____ 3 mo _____

ASA:_____ other_____

Health Assessment;_____

Dental Assessment:_____

Insurance Information

Subscriber Name_____ SS# _____/_____/_____

Relationship to Patient_____ Date of Birth_____/____/_____

Employer _____ Work #( ) -

Insurance Company_____ Phone #( ) -

Claim Mailing Address_____

Group#_____ Subscriber ID#_____

Initial Below

____ I assign dental insurance benefits to be paid directly to Dr. Jason W. Dyson, Parmer Oaks Dental Care

____ I understand that my insurance is an agreement between my employer (if applicable and me. I also understand that I am responsible for the balance of my account regardless of my insurance.

Financial Policy

- Payment is due at the time of service. We accept cash, checks, Visa, Mastercard, Discover and American Express.
- Your deductible and estimated co-pay is due at the time of service. We will file insurance claims for you as a courtesy.
- One half of payment is due upon appointing for crown and bridge with the balance due upon the prep appointment. Discounts may apply for payment in full upon appointment scheduling.
- We want you to enjoy the benefits of dental health. We are happy to work with you to make completion of your treatment possible and offer several financial options for treatment plans over $500.00. Our Financial Coordinator is available to consult with you the tailor a financial agreement to meet your specific concerns.
- All accounts over 90 days past due will be subject to a monthly finance fee. We utilize Transworld Systems, Inc. collection Service for unsettled account balances. A handling fee of $25.00 will be assessed for accounts assigned to collections.
- A $30.00 returned check fee will be assessed for items returned unpaid by your financial institution.

I understand and will abide by these financial policies set forth by Parmer Oaks Dental Care.

Date_____ Patient/Guarantor_____

Acknowledgement of Receipt of Notice of Privacy Practices Notice
(You may refuse to sign this Acknowledgement)

I,_____ have been presented with a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____

We have attempted to obtain written acknowledgement of our NPP, but could not be obtained because:

__ Refusal to sign acknowledgement __ Communication barriers prevented acknowledgement __ An emergency situation prevented Other_____