



Bay Family Dental Care, Inc.

WELCOME TO OUR OFFICE

Chart #: _____
FOR OFFICE USE ONLY

Patient Name: _____ Date: _____

Address: _____
Street City State Zip

Phone (home): (____) _____ (Work): (____) _____ (ext) _____ E-Mail: _____

Birth Date: _____ Social Security #: _____ Family Status: _____ Gender: _____

Whom may we contact in case of emergency: _____ Phone: _____ Relationship: _____

How did you hear about our office: _____

Health Information

Have you ever had any of the following? Please check individually

<p>Yes NO</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Growths</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Head Injuries</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervous Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Pregnancy Due date: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Treatment</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatism</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stomach Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p>	<p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Tumors</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex Allergy</p> <p>OTHER: <input type="checkbox"/> _____ <input type="checkbox"/> _____</p>
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- Have you ever had any complications following dental treatment? If Yes Please Explain _____ Yes No
- Have you been admitted to a hospital or needed emergency care during the past two years? If Yes Please Explain _____ Yes No
- Are you now under the care of a physician? If Yes Please Explain _____ Yes No
Name of Physician: _____ Record # _____ Address _____ Phone: _____
- Do you have any health problems that need further clarification? If Yes Please Explain _____ Yes No
- Have you ever taken the drug known collectively as "Fen-Phen" _____ yes No
- Are you taking any medication, drugs, or pills, over the counter? If Yes Please Explain _____ Yes No
- **To the best of my knowledge, all of the Following answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

Dental History

- Are you now in discomfort, requiring our immediate attention? _____ Yes No
- Have you had regular dental checkups? _____ Yes No
- When was your last dental visit? _____ What was done then? _____
- Have you been told you have gum problems? _____ Yes No
- Have you lost many teeth?/ exclude baby teeth If Yes Please Explain _____ Yes No

Responsible Party Information

Name: _____ Birth Date _____ Social Security No. _____

Relationship to patient _____ Employer: _____ Phone: _____

Address: _____

Dental Insurance Carrier: 1. _____ Dental Insurance Carrier: 2. _____

Address: _____

City State Zip Code City State Zip Code

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.



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Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Signature of Dentist: _____ Date: _____ Comments: _____

I, understand and acknowledge that I have reviewed the **DENTAL BOARD of CALIFORNIA'S DENTAL MATERIAL FACT SHEET** on the date indicated below.

Signature of Patient or Guardian _____
Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You have the right to refuse to sign this acknowledgement

I, _____, have reviewed a copy of this office **NOTICE of PRIVACY PRACTICES** as required by Federal law.

Signature of Patient or Guardian

Print patient's name

Date

Please Note: failed appointments with out 24 hour notice charges will be applied \$15.00 per 15 minutes appointment time scheduled _____INT.

UPDATE (to be filled out at future appointments)

Has there been any change to your health since your last appointment _____ yes _____no
For what condition/s? _____
Are you taking any medications? _____ If so what? _____
Patient's/Guardian's Signature _____ Date _____
Doctor's Signature _____ Date _____

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For what condition/s? _____
Are you taking any medications? _____ If so what? _____
Patient's/Guardian's Signature _____ Date _____
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