

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Patient No. _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home phone# _____ Work phone# _____

Email address _____ Social Security # _____

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone# _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone# _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone# _____

Dental Insurance

Primary Carrier

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Tel _____ Group # _____

Employer Name _____

Insured's Name _____

Insured's Date of Birth _____

Insured's SSN/ID# _____

Relationship to Patient _____

Secondary Carrier

Insurance Company _____

Address _____

City _____ State _____ Zip _____

Tel _____ Group # _____

Employer Name _____

Insured's Name _____

Insured's Date of Birth _____

Insured's SSN/ID# _____

Relationship to Patient _____

Dental History

Name: _____

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental x-rays _____

Please check if any of the following conditions apply to you:

___ Bad Breath

___ Grinding teeth

___ Sensitivity to hot

___ Bleeding Gums

___ loose teeth or broken filling

___ Sensitivity to sweets

___ Clicking or popping jaw

___ Periodontal treatment

___ Sensitivity when biting

___ Food collection between teeth

___ Sores or growths in your mouth

___ Sensitivity to cold

Medical History

Patient Name _____

Physician Name _____ Phone _____

Date of last visit _____ Reason _____

Please list all medications you are currently taking: _____

Have you ever had an allergic or adverse reaction to any medication or substance? Yes No

If yes, list medication _____

Describe reaction _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Do you have a history of the following? Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Latex Sensitivity	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Allergies or Hives	Yes	No
Artificial Heart Valve	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Chemotherapy	Yes	No
Rheumatic Fever	Yes	No	Tumors/Cancer	Yes	No
Arthritis/Rheumatism	Yes	No	Hepatitis A or B	Yes	No
Cortisone Medication	Yes	No	Hepatitis C	Yes	No
Swollen Ankles	Yes	No	STD	Yes	No
Stroke	Yes	No	A.I.D.S	Yes	No
Diet (Special/Restricted)	Yes	No	HIV Positive	Yes	No
Artificial Joints (Hip/Knee)	Yes	No	Cold Sores	Yes	No
Kidney Trouble	Yes	No	Blood Transfusion	Yes	No
Psychiatric/Psychological Care	Yes	No	Hemophilia	Yes	No
Ulcers	Yes	No	Sickle Cell Disease	Yes	No
Anorexia/Bulimia	Yes	No	Bruise Easily	Yes	No
Diabetes	Yes	No	Yellow Jaundice	Yes	No
Thyroid Problems	Yes	No	Epilepsy/Seizures	Yes	No
Glaucoma	Yes	No	Neurological Disorder	Yes	No
Contact Lenses	Yes	No	Fainting/Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous/Anxious	Yes	No
Emphysema	Yes	No			

History Review

Dentist Signature _____

Date _____

Authorization

I certify that I have read and understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. 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 carrier 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.

X _____

Consent For Use and Disclosure of Health Information (HIPAA)

Section A: Patient Giving Consent

Name of Patient: _____
(PRINT)

Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

*Berkeley Dental Center
2999 Regent St. Suite 714
Berkeley, CA 94705
(510)848-3143*

Right to Revoke: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

* If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.