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________________ SSN: ______________________________

Home phone#________________ Work phone#______________ Email: __________________

Do you prefer to receive calls at: (circle one) Home Work Either

Are you: (circle one) 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

_____ Bleeding Gums

_____ Clicking or popping jaw

_____Food collection between teeth

_____Grinding teeth

_____loose teeth or broken fillings

_____Periodontal treatment

_____Sores or growths in your mouth

_____Sensitivity to hot

_____Sensitivity to sweets

_____Sensitivity to sweets

_____Sensitivity to cold

Medical History

Patient Name________________________________

PhysicianName____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.

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

Are you taking *Coumadin*, *Warfarin*, or any other blood thinners? Yes No

Are you taking, or have you ever taken, Bisphosphonates? (Fosamax, *Boniva, etc.*) Yes No

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____ ______________________________

Patient or Guardian Signature Date

History Review

Dentist Signature: ______________________________________ Date______________________

Redwood Dental Financial Agreement

2025 Redwood Road Suite 3

Napa, CA 94558

Our goal is to provide the highest quality dental care and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, half of the payment is due at the first appointment.

Payment options:

1. Cash
2. Master Card
3. Visa
4. Discover
5. American Express
6. Credit card authorization for recurring charges if applicable

Patients with Insurance: The Patient and/or Guarantor is responsible for the **ESTIMATED** non-covered portion, as well as deductibles at the time of service.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Because doctor's time and personnel are reserved exclusively for your scheduled appointment, there is a **$75.00 FOR A BROKEN APPOINTMENT LESS THAN 48 HOURS IN ADVANCE.**

I, ______________________________, agree to these financial terms.

Signature ______________________________ Date ________________

Consent for Use and Disclosure of Health Information (HIPAA)

Name of Patient: ____ Date: ____________________

PATIENT / GUARDIAN: 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 Private Practices: You have the right to read our Notice of Practices before you decide to sign the 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 out Notice is available at your request in our office. We reserve the right to change our privacy practices, we will issue a revised Notice of Policy which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

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

REDWOOD DENTAL

2025 Redwood Road Suite 3 Napa Ca. 94558

(707) 255-5100

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 the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that may decline to treating you if you revoke this consent.

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

Patient/Guardian Signature: ______________________________________ Date: ________________

Relationship to Patient: ____ Date: ________________

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