Welcome to
Dentistry By the Bay!

Please complete the following pages so that we can get to know you better.

Patient Information:

First Name: ______________________MI: _____Last Name: ___________________________

Address: ___________________________ City: ____________________State/Zip: _________

Home Phone: _______________ Work Phone: _______________ Cell: ___________________

Birth Date: __________________ Social Security Number: _____________________________

Marital Status: _______________ Sex: __________E-mail address: _____________________

Previous Dentist: _________________

Emergency Contact: ______________________________Relationship: __________________

Phone Number: _____________________

Dental Insurance:

Subscriber name (first & last): ___________________________Relationship: ______________

Phone Number: ________________ Birthdate: ______________Employer: ________________

Insurance Company: _______________________Group Number: _______________________

Subscriber ID: ___________________________Subscriber's SS#: _____________________

Responsible Party (if someone other than patient):

First Name: ______________________MI: _____Last Name: ___________________________

Address: ___________________________ City: ____________________State/Zip: _________

Home Phone: _______________ Work Phone: _______________ Cell: ___________________

Birth Date: __________________ Social Security Number: _____________________________

How did you hear about our office?

Newspaper		Internet search		Marketing event	
Sign out front		Google		Facebook	
Insurance Company		Website		Mailer	
Friend/family/staff (who can we thank)					
Referring Doctor (who can we thank)					

Dentistry By the Bay
Full Health History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? _____yes_____no If yes who ____
Have you ever been hospitalized or had an major operation? _____yes_____no
If yes please explain ____
Have you ever had a serious head or neck injury? ____yes____no
If yes please explain ____
Are you taking any medications, pills, or drugs? ____yes____no
If yes please list ____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphanates ____yes____no
If yes when ____
Are you on a special diet? _____yes_____no Do you use Tobacco? _____yes____no
Do you use controlled substances? ____yes____no Do you need to pre-medicate? ____yes____no
Do you take a blood thinner, Coumadin, Xarelto, or Heparin? _____yes_____no

Women: Are you…
Pregnant/trying to get pregnant? ____yes_____no Nursing? ____yes____no
Taking oral contraceptives? ____yes_____no

Are you allergic to any of the following?
Aspirin ___yes____no Penicillin ____yes____no Codeine ____yes____no
Metal ____yes____no Latex ____yes____no Sulfa ____yes____no
Local anesthetic ____yes____no Acrylic ____yes____no

Other:____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	YES	NO	Radiation	YES	NO	Congenital Heart Disorder	YES	NO
Hepatitis A	YES	NO	Anaphylaxis	YES	NO	Heart Disease	YES	NO
Anemia	YES	NO	Herpes	YES	NO	Alzheimers Disease	YES	NO
Arthritis/Gout	YES	NO	Epilepsy	YES	NO	Drug Addiction	YES	NO
Excessive Bleeding	YES	NO	Seizures	YES	NO	Emphysema	YES	NO
Asthma	YES	NO	Shingles	YES	NO	High Cholesterol	YES	NO
Blood Disease	YES	NO	Fainting	YES	NO	Artificial Joint	YES	NO
Breathing Problems	YES	NO	Dizziness	YES	NO	Irregular Heartbeat	YES	NO
Bruise Easily	YES	NO	Kidney Problems	YES	NO	Blood Transfusion	YES	NO
Chemotherapy	YES	NO	Headaches	YES	NO	Liver Disease	YES	NO
Heart Attack/Failure	YES	NO	Low Blood Pressure	YES	NO	Cancer	YES	NO
Pain in Jaw Joints	YES	NO	Mitral Valve Prolapse	YES	NO	Tonsillitis	YES	NO
Ulcers	YES	NO	Osteoporosis	YES	NO	Tuberculosis	YES	NO
Heart Pacemaker	YES	NO	Psychiatric Care	YES	NO	Diabetes	YES	NO
Hepatitis B or C	YES	NO	High Blood Pressure	YES	NO	Artificial Heart Valve	YES	NO
Sickle Cell Disease	YES	NO	Sinus Trouble	YES	NO	Leukemia	YES	NO
Stroke	YES	NO	Thyroid Disease	YES	NO	Chest Pains	YES	NO
Cold Sores	YES	NO	Fever Blisters	YES	NO	Parathyroid Disease	YES	NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes.

Patient Signature____Date___________________________________

Smile Evaluation

How long has it been since you were last at the dentist? ____

What is your main concern today?

	Tooth Pain		Cavities/Decay		Missing Teeth
	Sensitivity		Cosmetic Dentistry		Implants
	Broken/fracuted Teeth		Cleaning		Gum Disease
	Whitening		Dentures		Orthodontics
	Gum Recession	Other:			

If our doctors find an issue that can be addressed immediately, are you interested in having treatment done today? ____yes____no

Do you have anxiety, fear or bad experiences associated with the dentist office? ____yes____no
If yes, please explain____

Do you like the appearance of your smile and look of your teeth? ____yes____no
If no, please explain____

What is most important to you when seeking dental treatment?

	Quality of service		Cost		Convenient hours
	Kind team members		Comfort		Technology
OTHER:					

Clicking/popping of jaw	YES	NO	Periodontal (gum) treatment	YES	NO
Clenching/grinding of teeth	YES	NO	Diagnosed with Sleep Apnea	YES	NO
Do you wear a Bite Splint	YES	NO	Bad breath or dry mouth	YES	NO
Orthodontic treatment	YES	NO	Extraction of any teeth	YES	NO
Other:					

How many times a day do you brush?____How many times a day do you floss?____

Do you use a waterpick? ____yes____no

Do you drink pop, sports drinks or sweet tea? ____yes____no If yes, how many per day? ____

May we take the necessary dental x-rays in order to provide you with an accurate diagnosis?
____yes____no

Is there anything else you would like for us to know about you?

____

We welcome and appreciate the opportunity to provide for your dental needs. We do our best to provide you with superior dental and patient care. Please read this document thoroughly and sign the bottom acknowledging that you have read and understand this document. We will provide you a paper copy at the end of you visit today for your records.

Financial Guidelines: We do a complimentary insurance benefit check for those patients who have dental insurance coverage to better understand your coverage. We will accept assigned benefits paid directly to our office. We will estimate as closely as possible what portion your insurance will cover. We will collect estimated co-payments and deductibles on the day services are rendered. After 90 days, the balance on the account will be due in full from you if your insurance has not paid, as you are responsible for all payments made to your account. Patients without insurance are expected to pay in full by cash, check or major credit cards the day services are rendered. We do offer Care Credit, please feel free to ask someone about this service.

Appointments: We make every effort to provide dental service in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you most efficient care, we work within an appointment system and your appointment times are reserved especially for you. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment. If you are more than 15 minutes late for your appointment, we may need to reschedule you to allow enough time for your treatment.

Cancellation Policy: I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least twenty-four (24) hours in advance of my scheduled appointment time. I understand that I will need to call the office to confirm my appointment within twenty-four (24) hours. I understand that if I do not call the office to confirm my scheduled appointment, my appointment may be released to another patient. Please note schedule changes will be accepted only during regular office hours. I am aware that I may be charged a fee if I do not provide twenty-four (24) hour notice of a cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $45. If you fail to show up for two (2) appointments, we may not be able to schedule you for any more appointments and may be dismissed from the practice.

If you understand and agree to the above guidelines for our office, please sign below:

Signature: ____Date: __________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient:

__________________________________ Print name: ____