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:_____ SSN:_____-_____-_____

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

____ 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 when biting

____Sensitivity to cold

Medical History

Patient Name_____

Physician Name_____Phone_____

Date of last visit_____ Reason_____

Covid 19 Vaccination Yes No If Yes date:_____

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_____

Smoking Yes No - If yes how many years? _____

(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_____

Patient/Parent or Guardian Signature Date

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:

Pacific Heights Dental
2383 California Street
San Francisco, CA 94115

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.

Pacific Heights Dental

Financial Policy

Our primary goal is to deliver the finest and most comprehensive dental care services available today. We look forward to caring for your dental health and establishing a long lasting professional relationship. Payment is expected for all treatment rendered, so take a moment to look over the types of payment we accept.

Payment Options:

1. Personal or cashier's check.
2. Visa, MasterCard, Discover Card, and American Express.

Insurance:

We will be happy to send your insurance forms in for you and answer questions regarding coverage. Realize submission to your insurance company is not a guarantee of payment. Any balance your insurance company does not cover will be your responsibility.

Missed Appointments:

Once an appointment has been made, remember this time is reserved specifically for you, our patient. We confirm appointments 48 hours in advance as a courtesy to you. We require you to also give us 48 hours notice if you must cancel your appointment. A cancellation fee of $75 is charged for a missed appointment.

Financial Consent:

The patient, or guardian, agrees to be fully responsible for total payment of treatment preformed in this office.

I have read, understand and agree to this Financial Policy.

X_____ _____

Patient/Parent or Guardian Signature Date