# PATIENT INFORMATION RECORD

The following confidential information is for our records only.

Today's Date: ________ Birthdate: ________ | 13 years or under? ____

Patient's Name: ___ ___________________________________
Mr. Mrs. Ms. Dr. Other | Last name | First name | Middle name

Name you prefer to use: ______________________________ Best method to reach you: ___________________________

Address: ___________________________________________________________________
Street | Apt/Condo# | City | State | Zip

Home Phone: ( )___________________ Cell Phone: ( )______________________ E-mail:________________@________

Driver's License Number (ID#): ___________________________ Social Security Number: ________/______/_________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other

Name of Person Responsible for Account: _________________________________________ Relationship: _____________

Patient's Employer: __________________________Occupation: ____________________Work Phone: ( )_________X__

Work Address: ________________________________________ City: ________________ State: _____ Zip: ___________

Whom may we thank for referring you? _____________________________________ Relationship: __________________

Emergency Contact: ______________________________Relationship: ____________________ Phone: ( )__________

## INSURANCE INFORMATION

Insured's Name_____________________________ Relationship: __________________ Birthdate: ___________SS#:_____/_____/______

Insured's Employer: ____________________ Phone: ( ) _____________ Name of Insurance Co: ___________________ Group#: _______

Insurance Address: ________________________________________________________ Insurance Phone #: ( )_________________

Do you have Secondary Insurance: ☐ Yes ☐ No

**ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT OF FEES.** If you have insurance, we will gladly process your forms, but a payment of deductible and/or co-payment is expected on the day of service. If you cannot keep an appointment, please give us 48 hours notice so that the time maybe given to another patient.

I understand that any procedure carries some risk. I will give my consent to the dental staff to perform any necessary dental services that I may need only when risks, benefits and alternatives are discussed. I understand and agree to the insurance/financial and cancellation policy. In addition, I herby authorize _____________, DDS, to sign and submit insurance claims on my behalf. I understand that this authorization will assign all insurance benefits directly to _______________, DDS.

Patient's or Legal Guardian's Signature: ______________________________ Name(print): _______________________________ Date: ______________

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## DENTAL HISTORY

Reason for Today's visit: _________________________ Date of last dental visit: ____________ Date of last dental x-rays: _________

Reason to change dentist: _________________________ Former Dentist: ______________________ Phone: ( ) ________________

Are you currently in pain? ☐ Yes ☐ No

Do you have pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Your sugar intake is? ☐ High ☐ Medium ☐ Low

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No ☐ Maybe

Is there anything you'd like to change about your smile? ☐ Yes ☐ No

How many times a week do you floss? _______ How many times a day do you brush? ________ Do your gums ever bleed? ☐ Yes ☐ No

The toothbrush that you sue has which type of toothbrush bristles? ☐ Soft Medium ☐ Hard ☐ Don't know

Have you ever had any of the following? ☐ Wisdom teeth surgery ☐ Braces ☐ Gum surgery ☐ Dentures or implants ☐ Mouthguard

Do you clench or grind your teeth? ☐ Yes ☐ No

Have you ever had a problem with any previous dental work? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name ________________________________ Phone: ( ) _______________ Fax: ( ) ________________
Address: ____________________________________________________________ Date of last visit: ________________

Are you currently under the care of a physician due to an illiness? ☐ Yes ☐ No
Are you taking any prescription/ over-the-counter **medications** or herbal supplement? ☐ Yes ☐ No
If yes, please list each one: ____________________________________________________________________________

Have you ever taken or are you taking: ______ Bisphosphonates ______ Coumadin/Baby Aspirin _____ Phen-Fen

For women only: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant or nursing? ☐ Yes ☐ No

Please indicate with a check mark ☐ if you ever had any of the following:

- ☐ Abnormal bleeding
- ☐ Alcohol/drug abuse
- ☐ Anemia
- ☐ Arthritis/ Rheumatism
- ☐ Artificial Heart valve*
- ☐ Artificial joints/ bones*
- ☐ Asthma
- ☐ Back problems
- ☐ Blood transfusion
- ☐ Cancer/ chemotherapy radiation therapy
- ☐ Colitis
- ☐ Congenital Heart Defect- unrepaired
- ☐ Cortisone treatment
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery/ Transplant
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/ Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+/ AIDS
- ☐ Hospitalized
- ☐ Infective Endocarditis*
- ☐ Kidney problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve
- ☐ Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problem
- ☐ Rheumatic/ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Cigarettes/ Tobacco Use
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: __________________

Are you **allergic** to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex gloves
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other:
  ________________________
  ________________________
  ________________________
  ________________________

The above information is accurate and complete to the best of knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status.

Patient's or Legal Guardian's Signature: ________________________ Name (print): ______________________ Date: ____________

Dentist's Signature: ________________________________________ Name (print): ______________________ Date: ____________

# Nob Hill Dental
# Maria Pham, D.D.S

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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**SECTION A: PATIENT GIVING CONSENT**

**Name:** ______________________________________________________________________________

**Address:** ______________________________________________________________________________

**Telephone:** ______________________________________________________________________________

**Social Security:** ______________________________________________________________________________

**SECTION B: TO THE PATIENT – 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 whether 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, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to 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 Practices, 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:

**Contact Person:** Sue C.
**Address:** 1200 Pacific Avenue, San Francisco, CA 94109
**Telephone:** (415) 673-3311 **Fax:** (415) 673-1632

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action continue treating you if you revoke this Consent.

**SIGNATURE**

I, (print name) ____________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your 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, complete the following:**

Personal Representative's Name: ___________________________________

Relationship to Patient: ___________________________________________

Nob Hill Dental
Maria Pham, DDS
1200 Pacific Avenue
San Francisco, CA 94109

# Consent for Financial Agreement

- ❑ I choose to pay upfront with cash / check / credit card / ATM

C.c. # ______________________________________________ Exp.Date: _______________

3 digit #_________________

- ❑ I choose to have my insurance billed and pay the remaining balance on my credit card.

C.c. # ______________________________________________ Exp.Date: _______________

3 digit # ________________

**For Patients With Insurances:**

We will collect your estimated patient portion or co-pay upfront or at the time of services rendered. If the insurance happens to cover more, the overpayment will refund to you. If they cover less than the estimated amount, we will charge your credit card for your remaining balance. We can inform you about the charges;

- ❑ Please charge my credit card without calling for the balance
- ❑ Please inform me prior to the charge
- ❑ Please inform me prior to the charges above_________.

Insurance companies are separate entities that the patients bring along to our office in terms of their financial coverage. As a courtesy to our patients, we will bill your insurance company and follow up. Occasionally, we may need your help to collect payment for the services you had already received. This may actually be more effective since you are the client of the insurance company.
If the insurance company fails to pay the balance after 60 days of the billing, we will ask you to pay the full amount. There will be a late payment charge of 1.5% per month for the outstanding balance.

I understand and agree with the above,

Name__________________________________________________________________________

Signature_________________________________________ Date________________________