Guadalupe Dental Care

2593 South King Rd. Suite #9
San Jose, CA 95112

Welcome!

Patient Name: _____ DOB: _____ Gender: F / M

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____Occupation: _____

Business Address: _____ City: _____ Zip: _____

Business Phone: _____ Ext: _____

Responsible Party (if different from above)

Name: _____ DOB: _____

Relationship with patient: _____

Insurance Information

Primary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____ ID# _____

Insurance Phone: _____ Group # _____

In the event of an emergency please contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

How did you hear about our office?

Referred by a friend	Relative	Insurance Plan	Penny Saver
Sign by Building	Mailer	Yellow Pages	Other

Other (Please explain here): _____

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs? Or Bisphosphonates?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

We welcome you to our family of dental care providers and we are committed to your treatment being successful. Please understand that payment of your bills is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of the service. We accept **cash, checks, VISA, MasterCard, American Express, Discover** or we offer **CareCredit** payment plan, which allows low monthly payments with prior credit approval.

Please indicate the method of payment you wish to settle to your account:

☐ Cash ☐ Check ☐ VISA ☐ MasterCard

☐ Discover ☐ American Express ☐ CareCredit Plan

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have complete insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company within 45 days of billing and the balance becomes your responsibility. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be clear in less than 45 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only **estimate** what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing

For all accounts over 45 days with patient amounts due, there will be a $10.00 billing fee or a finance charge of 1.5% per month, whichever is more. We assign all accounts over 120 days to a collections service for processing.

There will be a charge of $50.00 for canceling an appointment without 48 hours notice or for failing to show to an appointment.

Should this account become past due, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this account.

I have read and I agree to this financial policy.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Staff Signature Date