Patient Name_____Date _____
Preferred Name_____
Address _____City _____
State _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____ WorkPhone _____
Social Security # _____ Referred By _____

Sex M F Birthdate ___/___/_____ Status: Single Married Widowed Divorced

Employed by _____Occupation_____

Emergency Contact: _____ Phone_____

MEDICAL HISTORY

Physicians Name _____Date of Last Physical _____

Have you ever been told you need to premedicate before a dental procedure? Y / N

Allergy/reaction to: Anesthetics, Aspirin, Codeine, Iodine, Latex, Penicillin, Sulfa, Other _____

Have you ever had any of the following? (check which apply)

__AIDS/HIV	__Glaucoma	__Nervous Problems
__Arthritis	__Headaches	__Pacemaker
__Artificial Heart Valves	__Heart Murmur	__Psychiatric Care
__Artificial Joints	__Heart Problems	__Radiation Treatment
__Asthma	__Hepatitis	__Respiratory Disease
__BackProblems	__Herpes	__Rheumatic Fever
__Cancer	__High BloodPressure	__SinusTrouble
__Chemical Dependency	__Jaw Pain	__Skin Rash
__Chemotherapy	__Kidney Disease	__Stroke
__Circulatory Problems	__Liver Disease	__Thyroid Problems
__Diabetes	__Low BloodPressure	__Tuberculosis
__Epilepsy/Seizures	__Mitral ValveProlapse	__Ulcers Other _____

IF NO MEDICAL CONDITIONS PLEASE CHECK HERE ____

What medications do you currently take? _____

_____

DENTAL HISTORY

Are you happy with your smile? Yes / No Are you anxious about dental treatment? Yes / No

Would you like to be sedated? Yes / No Do you use tobacco products? Yes / No

Women: Are you pregnant? Yes / No Nursing? Yes / No Taking Birth Control Pills? Yes / No

Office Financial and Appointment Policy

Thank you for choosing the office of Al Villalobos, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care manageable for our patients. We will help you receive your maximum allowable benefit.

Payment: Patient payment in full is due at the time services are rendered. We offer several payment options:

- Cash, Check, Visa, MasterCard, Discover, or American Express
  Monthly payment plans from CareCredit[1]

Patients without Dental Insurance: Payment in full is due at the time of service, unless alternate arrangements have been previously made before treatment.

Patients with Dental Insurance

- We will file claims on your behalf for services rendered[2]
- Not all services are covered under all insurance contracts
- Your insurance is a contract between you and your insurance carrier. We will provide you estimates based on the information that your insurance carrier provides to us
- Co-pays are due at the time of service
- Please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner

Appointments: Required for all visits.
Hygiene appointments are in high demand, confirmation is required 24 hours notice or we will cancel your appointment.

There is a $75.00 fee for all appointments that are missed or canceled without 24 hour's notice. We are aware that emergencies do sometimes arise.

Signature of Responsible Party Date _____

_____

[1]Subject to credit approval

[2] If we do not receive payment from your insurance carrier within 90 days, you will be responsible for the payment of your treatment fees and collection of your benefits directly from your insurance carrier

HIPAA

Due to HIPAA regulations, we only will share your information with the person(s) that you specify. **Please list the full legal name** of all individuals below that you authorize us to discuss treatment, including financial information.

1._____ INSURANCE COMPANY

2._____ Spouse/Significant Other

3._____ Relationship _____

4..._____ Relationship _____

5..._____ Relationship _____

I do authorize the office of Dr. AI Villalobos to discuss necessary information when requested by one of the above individuals.
I may revoke my permission to any individual at any time in writing.

Patient, Parent or Guardian Signature

_____ Date _____