

**WEST VALLEY PERIODONTICS  
NEW PATIENT INFORMATION SHEET**

TITLE: Mr \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Miss \_\_\_\_\_ Dr. \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_  
          LAST                    FIRST                    MIDDLE  
ADDRESS: \_\_\_\_\_ APT NO.: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CELLULAR PHONE: \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_ EXP: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_  
SPOUSE NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_  
GENERAL DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

INSURANCE NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME OF INSURED PERSON: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_ INSURED SOCIAL SECURITY: \_\_\_\_\_  
IS THERE A 2ND INSURANCE?  YES  NO  
2<sup>ND</sup> INSURANCE NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
NAME OF INSURED PERSON: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_ INSURED SOCIAL SECURITY: \_\_\_\_\_

**CONSENT FOR SERVICES**

1. I understand that PAYMENT for dental services provided by this office, for either ME or MY DEPENDENT, is MY RESPONSIBILITY AND IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.
2. PATIENTS WITH DENTAL INSURANCE: I UNDERSTAND THAT ALL DENTAL SERVICES PROVIDED ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES, WHETHER MY INSURANCE PAYS OR DOES NOT PAY. AS A COURTESY, THIS OFFICE WILL ASSIST ME WITH PREPARING MY INSURANCE FORMS AND IN OBTAINING REIMBURSEMENT FROM MY INSURANCE COMPANY.
3. I give my consent to allow West Valley Periodontics to receive payment directly from my insurance company, but understand that this office cannot render services based on the assumption that an insurance company will pay.
4. As a condition of my treatment by this office, any financial arrangements must be made in ADVANCE, prior to actual treatment. I understand the practice depends upon financial reimbursement from its patients.
5. I understand that any fee estimate listed for my dental care, can only be extended for a period of 6 MONTHS from the date of my examination.
6. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless a previously written and signed financial arrangement exists and is being satisfied. I further agree to pay all financial charges, collection costs, 50% of attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding on my account.
7. I agree to pay the fee of \$35 if I fail to give at least a 24 hour notice upon canceling any appointment.
8. All emergency services, or any dental services performed without previous financial arrangements, must be paid for in full at the time of service.
9. I hereby authorize West Valley Periodontics to release any of my information that may be required to third party payer and/or health practitioners.
10. I grant my permission to West Valley Periodontics or your assignee, to telephone me at home or at my work to discuss matters related to this form.
11. I have read the above conditions of treatment and agree to their content.

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

## MEDICAL HEALTH INFORMATION

Do you have any serious medical conditions that we should be aware of? Yes\_\_ No\_\_

If yes, please describe: \_\_\_\_\_

Are you currently being treated by a physician for any medical condition? Yes\_\_ No\_\_

If yes, please describe: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Have you been hospitalized or had any operations in past two years? Yes \_\_ No\_\_

If yes, when & why \_\_\_\_\_

Do you have any allergies or sensitivity to any medication? Yes\_\_ No\_\_

Please list: \_\_\_\_\_

Do you smoke cigarettes? Yes\_\_ No\_\_ How much in a day? \_\_\_\_\_

Do you use chewing tobacco? Yes\_\_ No\_\_ How much in a day? \_\_\_\_\_

Do you frequently smoke a pipe or cigars? Yes\_\_ No\_\_

WOMEN: Are you pregnant? Yes\_\_ No\_\_ Do you suspect that you could be? Yes\_\_ No\_\_

If yes how far along are you? \_\_\_\_\_ Are you nursing or lactating? Yes\_\_ No\_\_

*\*\*please note that effectiveness of oral contraceptive can be impaired by antibiotics used*

### Have you ever had any of the following? Please check those that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergies<br>_____              | <input type="checkbox"/> Hay fever                     | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Head injuries                 | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Heart disease                 | <input type="checkbox"/> Stroke Date _____    |
| <input type="checkbox"/> Artificial joint<br>Date: _____ | <input type="checkbox"/> Heart attack                  | <input type="checkbox"/> Sickle Cell disease  |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Heart surgery                 | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Blood disease                   | <input type="checkbox"/> Heart murmur                  | <input type="checkbox"/> Stomach problems     |
| <input type="checkbox"/> Blood transfusion               | <input type="checkbox"/> Congenital heart disease      | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Bruise easily                   | <input type="checkbox"/> Artificial heart valve        | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Heart pacemaker<br>Date _____ | <input type="checkbox"/> Codeine allergy      |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Penicillin allergy   |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Mitral Valve Prolapse         | <input type="checkbox"/> AIDS/ HIV:           |
| <input type="checkbox"/> Epilepsy or seizures            | <input type="checkbox"/> Jaundice                      | <input type="checkbox"/> Latex allergy        |
| <input type="checkbox"/> Excessive bleeding              | <input type="checkbox"/> Kidney disease                | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> OTHER:<br>_____      |
|  | <input type="checkbox"/> Mental Disorder               | _____   |

Have you ever had any complications following dental treatment? Yes\_\_ No\_\_

If yes, please describe: \_\_\_\_\_

*To the best of my knowledge, all preceding answers and information provided are true and correct. I authorize the periodontist to contact my family physician and/or any medical specialist that I have listed above to obtain further medical information if necessary. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.*

\_\_\_\_\_  
Printed Name of Patient or Guardian Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Doctor Date: \_\_\_\_\_

# OFFICE FINANCIAL POLICY

## West Valley Periodontics

In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payments.

- \* Discover
- \* Visa
- \* Master card
- \* Cash
- \* Checks
- \* Debit card

### \*\* PREPAYMENT

We are happy to offer a 5 % discount for services over \$300.00 when prepaid in full upon scheduling your appointment.

We also offer two financing options which are administered for us by  
 Care Credit    Citi Health Card (over \$300 treatment plan).

If a patient has a fee reduction plan or any other insurance, we will not bill care credit or Citi Health. Patients will have to choose care credit or their insurance.

*Please ask our administrative staff for details and credit applications.*

- We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.
- We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometime complicated task.

**I agree that I am fully responsible for the total payment of all procedures performed in this office –this includes any treatment that is not a covered benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within sixty (60) days of the date of service, regardless of whether or not my insurance benefits have been received. One and one-half percent( 1.5%) per month interest (18% per year ) will be charged on accounts 60 days from treatment date.**

### MISSED APPOINTMENTS

*Appointment times are reserved especially for you and it is bond of trust between you and our office. In helping us serve you better please keep your scheduled appointments. Our time is dedicated to high quality services at reasonable cost and in order to deliver this we ask that you choose a time that you will be committed to, it is important that you notify us at least **48 hours before** your appointment if you need to cancel or reschedule. We reserve the right to charge a \$35.00 missed appointment fee for broken/missed appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.*

Signature (Responsible party)

Financial Coordinator

Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT  
(HIPAA ACT)  
PRIVACY POLICY ACKNOWLEDGEMENT  
WEST VALLEY PERIODONTICS

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_ SS: \_\_\_\_\_

I verify that the information given on health history form is true and correct.

- I understand that the office and staff of West Valley Periodontics will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone numbers.
- I understand that there may be times when the doctor and staff will need to speak with me regarding an appointment time, a test result or financial arrangements. If I am not at the number given, they have my permission to leave a brief message at my home or work number provided.
- I give my permission to West Valley Periodontics and staff to correspond with my general dentist, general physician, or specialist that I am under care with.
- I understand that my test result or health information will only be given to me or my legal guardian and cannot be given to my spouse or other family members.
- Upon my request, I will be given a full and complete copy of HIPAA privacy policy.
- If there are specific restrictions on use of my personal health information, I will notify West Valley Periodontics or Dr. Bohra in writing of these restrictions.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

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