

WEST VALLEY PERIODONTICS

NEW PATIENT INFORMATION SHEET

NAME: _____ NICKNAME: _____
LAST FIRST MIDDLE
ADDRESS: _____ APT NO.: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ BEST TIME TO CALL: _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
EMAIL: _____ D.L. NUMBER: _____ EXP: _____
EMPLOYER: _____ OCCUPATION: _____
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

PRIMARY DENTAL INSURANCE:

INSURANCE NAME: _____ GROUP #: _____ ID#: _____
CLAIMS ADDRESS: _____ PHONE: _____
NAME OF INSURED PERSON: _____ EMPLOYER: _____
INSURED SOCIAL SECURITY: _____ INSURED DATE OF BIRTH: _____

SECONDARY INSURANCE:

INSURANCE NAME: _____ GROUP #: _____ ID#: _____
CLAIMS ADDRESS: _____ PHONE: _____
NAME OF INSURED PERSON: _____ EMPLOYER: _____
INSURED SOCIAL SECURITY: _____ INSURED DATE OF BIRTH: _____

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 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 ENTIRE COST OF TREATMENT. AS A COURTESY, THIS OFFICE WILL ASSIST ME WITH PREPARING MY INSURANCE FORMS AND WILL MAKE EVERY EFFORT IN OBTAINING REIMBURSEMENT FROM MY INSURANCE COMPANY. I UNDERSTAND ANY DEDUCTIBLE AND ESTIMATED CO-PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE.
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. I agree to notify the office immediately if there are any changes regarding my insurance coverage.
4. As a condition of my treatment by this office, any financial arrangements must be made in ADVANCE, prior to the actual treatment. I understand the practice depends upon financial reimbursement from its patients.
5. 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.
6. I agree to pay the fee of \$35 if I fail to give at LEAST a 24 hour notice upon canceling any appointment.
7. I agree to pay the fee of \$35 for any returned check.
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 my dental insurance company, 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: _____

WEST VALLEY PERIODONTICS

MEDICAL HISTORY

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? Yes___ No___ How much in a day?_____

Do you use chewing tobacco? Yes___ No___ How much in a day?_____

Have you ever had any complications following dental treatment? Yes___ No___

If yes, please describe: _____

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
Describe:_____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorder
Describe:_____ |
| <input type="checkbox"/> Artificial Joint
Date:_____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Describe:_____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Blood Disease
Describe:_____ | <input type="checkbox"/> Heart Attack
Date:_____ | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Blood Thinner Meds
Name:_____ | <input type="checkbox"/> Heart Surgery
Date:_____ | <input type="checkbox"/> Stroke
Date:_____ |
| <input type="checkbox"/> Bisphosphonate Meds
Name:_____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replacement
Date:_____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other
_____ |

To the best of my knowledge, all preceding answers and information provided are true and correct. I authorize West Valley Periodontics 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 office as soon as possible.

PRINTED NAME OF PATIENT

DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

DOCTOR SIGNATURE

DATE

WEST VALLEY PERIODONTICS

OFFICE PRIVACY POLICY

(HIPAA)

PATIENT NAME: _____ DATE: _____
PATIENT'S DATE OF BIRTH: _____ SOCIAL SECURITY: _____

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 test results or health information will only be given to me or my legal guardian, and cannot be given to my spouse or other family members without my written consent.
- 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.

I authorize West Valley Periodontics to discuss my personal information with the following people, in addition to my insurance company, physician or dentist:

_____ Name	_____ Relation
_____ Name	_____ Relation
_____ Name	_____ Relation

SIGNATURE OF PATIENT/GUARDIAN

DATE

WEST VALLEY PERIODONTICS

OFFICE FINANCIAL POLICY

Our goal at West Valley Periodontics is to ensure that you have an outstanding experience in our office. We are committed to supporting you in understanding your dental health, so that you will always be able to make the best choices in regards to your treatment. We are here to assist you in any way possible. Please make your questions and concerns known to our team.

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.

- * Visa
- * Visa Debit
- * MasterCard
- * Discover
- * Cash
- * Check (There is a \$35.00 charge for any returned check.)

We also offer two financing options for treatment over \$300.00, which are administered for us by:

- * Care Credit
- * CitiHealth Card

Please ask our administrative staff for details and credit applications.

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- ONE AND ONE-HALF PERCENT (1.5%) PER MONTH INTEREST (18% PER YEAR) WILL BE CHARGED ON ACCOUNTS THAT STILL CARRY A BALANCE 60 DAYS FROM TREATMENT DATE. 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.

MISSED APPOINTMENTS

*Appointment times are reserved especially for you and it is a bond of trust between you and our office. In helping us to serve you better please keep your scheduled appointments. Our time is dedicated to high quality services at reasonable costs. In order to deliver this to all of our patients, we ask that you choose a time that you will be committed to. It is important that you notify us at least **24 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*

PRINTED NAME OF PATIENT

DATE

SIGNATURE OF PATIENT/GUARDIAN

TREATMENT COORDINATOR