Steven Adame, DDS and Raul Montalvo DDS

(separate and distinct unrelated entities but choose to share common paperwork for convenience as they share office space)

Patient Information

(This information is necessary for our files and will be considered ***CONFIDENTIAL*** under the Health Information Portability and Accountability Act)

Last Name	
First Name/ Middle Initial	
Home Address	
City/State/Zip	
Social Security No. (for Insurance Purposes)	
Home Phone	( ) –
Cell Phone	( ) –
Employer	
Work Phone	( ) –
E-mail Address	
Gender	☐ Male ☐ Female ☐ ____________
Birth Date	MM / DD / YYYY
Source of Referral (if any)	

Your Dental Insurance	Through:	☐ Your Employer ☐ Individually-Owned
	Insurance Company:	
	Group Number:	
	Insurance ID (if not SSN):	
Spouse/Other Dental Insurance	Subscriber is:	☐ Spouse ☐ Self ☐ Other
	Full Name of Spouse/Other:	
	Date of Birth of spouse/other:	MM / DD / YYYY
	Insurance Company:	
	Group Number:	
	Insurance ID/ SSN	

The above information is correct to the best of my knowledge and belief.

Signed: ______________________________ Date: ______________________

Relationship to Patient (if Surrogate): ______________________________

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FINANCIAL AND POLICY ACKNOWLEGEMENT, AND CONSENT TO TREATMENT

We ask that you read and initial each of the following policies. ***Your initials and signature at the bottom indicate that you have read, understand, and agree to each***, so please ask questions if you need clarification.

_____ **PERSONAL FINANCIAL RESPONSIBILITY**: In general, I understand services furnished to me (or my dependent) are ***charged directly to me and I am responsible for payment of all such services***, ***whether or not I carry or acquire valid dental insurance***.

_____ **PAYMENTS/DISPUTES/WAIVER FOR BREACH**: I agree to pay for all services at the time performed, unless credit is extended under specified terms (see section on Insurance below), in which case I will pay ***within 30 days of billing***. I understand the office accepts a personal check, most major Credit Cards (as well as by Debit or Checkcards that can be used like these credit cards without a "PIN"), and CareCredit. I will challenge any charges within 30 days of payment or billing, whichever applies. I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver for any further term or condition. I agree that should either the office or I institute legal proceedings regarding amounts owed by me, the prevailing party shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

_____ **INSURANCE**: If I have (or acquire) insurance, I understand the office will attempt to process my claim and extend credit for a reasonable time to allow processing, but ***I may be requested to pay any co-payment, deductible, and/or estimated portion of costs when services are rendered***. If there is a ***significant delay*** in payment by insurance***, I may be asked to pay for the services*** and to resolve the matter directly with the insurance company. I understand that ***dental insurance may NOT always fully cover all services that I may require*** and that ***I remain fully responsible for all services rendered as the office cannot perform services on the assumption charges will be paid by insurance***. I understand the office will offset any charges by amounts paid by insurance and make any adjustments required under the terms and conditions of any insurance with which the office has entered into a contract or agreement. I understand each policy is different and there is no way for the office to know the details of every one. As the owner of the policy, ***I am responsible for knowing what my plan covers and what it does not***, and I agree to pay ***any remaining balance should my insurance eventually not cover a specific service or pays an amount different than what was estimated***. I am also responsible for contacting my insurance company directly should I have questions the office cannot reasonably assist me with or to resolve problems that may arise.

_____ **FUTURE CHANGES TO INFORMATION PROVIDED**: I am responsible for informing the office of any changes in my contact information, any insurance coverage, ***as well as any changes in my medication(s) or health status since my last visit***.

_____ **X-RAYS**: I understand Dr. Adame requires performance of a full-mouth series of X-rays on all new patients as part of a complete assessment unless I can provide a set taken within 3 years. In that case, the current status of my teeth will determine the need for X-rays. I will arrange for my previous dentist to forward any prior X-rays. I understand, to the degree permitted by law, ***the office may charge for X-ray processing should I need them forwarded elsewhere, and my prior dentist may similarly charge for this service.***

_____ **ASSIGNMENT OF BENEFITS**: I authorize my insurance company, or represent that the subscriber of a policy under which I am covered authorizes that company, to pay benefits accruing under such policy to the office/dentist.

_____ **AMALGAM (METAL) FILLINGS NOT OFFERED**: I understand Dr. Adame uses composite resin (tooth colored) material that bonds with the tooth, not amalgam (metal) filling material, and that the cost of a resin filling is ***approximately 15% higher***. I understand any insurance I may have ***may not fully cover*** the cost of resin fillings, so ***I would be responsible for any balance*** after the office receives what the insurance will pay and applies any required adjustments.

_____ **FEE ESTIMATES**: I understand that fee estimates provided to me are only valid for ***three months*** unless otherwise indicated.

_____ **FINANCE CHARGES**: I understand, to the degree permitted by law, I may be charged 1½% per month (18% per year) or the maximum permissible rate under law, whichever is less, if my account is not paid within 60 days of my treatment date or a date otherwise agreed upon.

_____ **BROKEN APPOINTMENT FEE**: I understand the office has reserved a unit of time especially for me and that the office requires that I give at least 24 hours notice if I need to cancel or reschedule my appointment so that the office may offer the time to someone else. ***I understand there will be a charge for any appointment cancelled or missed without 24 hours notice. The amount is currently $50, but may be increased in the future without further notice.***

_____ **CONTACTS**: I grant my permission for representatives of the office to contact me at home, work, or on a provided cell phone, to discuss matters related my care and responsibilities using reasonable means, including but not limited to telephone, text, and e-mail.

CONSENT: I grant authority to the dentist in charge of my (or my surrogate's) care, subject to ongoing informed consent, to administer or permit to be administered by authorized staff such **anesthetics, sedatives, nitrous oxide sedation, or other medications**, and to perform or permit to be performed by authorized staff **such operations and procedures as may be deemed necessary or advisable** in my (or my surrogate's) diagnosis/treatment.

I have ☐ **received or** ☐ **been offered and refused** a copy of the "California Dental Materials Information Sheet."

I have ☐ **received or** ☐ **been offered and refused** a copy of the Practice's "Notice of Privacy Practices"

I understand the most current versions are available on the practice website: www.stevenadamedds.com or www.raulmontalvodds.com

Name/Guarantor: ___________________________ Signature: ___________________________ Date: _____________

Patient (if not Guarantor): __________________________

PATIENT NAME____

DENTAL HEALTH HISTORY

[NOTE: Complete in BLACK OR BLUE Ink for Initial Visit]

IMPORTANT: Your responses are ***REQUIRED*** and, by law, ***CONFIDENTIAL***. They help assure any treatment needed will take into consideration your health status and, for example, things like the potential for ***interactions of drugs***. Please discuss any concerns with your dental professional.

Reason for your visit: ☐ Routine Cleaning/Exam ☐ Damaged Tooth ☐ Pain ☐ Other: ________________________

How long since your last full mouth X-rays?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never
How long since your last dental examination or treatment?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never
How long since your last routine physical exam?	☐ Less than 1 year	☐ 1-5 years	☐ More than 5 Years	☐ Never

MEDICATIONS, HERBS, AND/OR SUPPLEMENTS

I am ***sensitive or allergic*** to:
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Other Substance(s) (Specify):

____

____

☐ Yes ☐ No – I take hormones

I have taken (in the past) or take the following drugs:
- ☐ Fosamax (Bisphosphonate)
- ☐ Zometa
- ☐ Actonel
- ☐ Boniva
- ☐ Aredia

☐ Yes ☐ No – I take birth control pills (Women only)

Please List ***ANY other medications, herbs, or supplements*** you are ***taking or have taken in the last year***.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

GENERAL MEDICAL HISTORY *(Check ALL that you have or have had)*

☐ **NONE** of these	☐ Stomach Ulcers	☐ Stroke	☐ Cerebral Palsy	☐ Joint Replacement
	☐ Gastric Reflux/Heartburn	☐ Easy Bruising or Bleeding	☐ Autoimmune Disease	☐ Osteoporosis
☐ Hay Fever	☐ Arthritis	☐ High/Low Blood Pressure	☐ Drug Addiction	☐ Tumors/Cancer
☐ Herpes or Cold Sores	☐ TMJ Disorder	☐ Angina/Chest Pain	☐ Psychiatric Issues	☐ Chemotherapy
☐ Headaches	☐ Difficulty Swallowing	☐ Tuberculosis (T.B.)	☐ Thyroid Conditions	☐ Radiation Treatment
☐ Sinus Disease	☐ Sleep Apnea or Snoring	☐ Respiratory/Lung Disease	☐ Fainting	☐ HIV/AIDS
☐ Chicken Pox	☐ Heart Attack	☐ Kidney Disease	☐ Seizures/Epilepsy	☐ MRSA or Cellulitis
☐ Head Injury	☐ Heart Murmur	☐ Hepatitis	☐ Diabetes	☐ Sexually Transmitted Disease
☐ Glaucoma	☐ Other Heart Disease	☐ Other Liver Disease	☐ Implant(s)	

Please list ***ANY OTHER***
Medical Condition you have or have had: ____

Please answer each question:

- ☐ Yes ☐ No – I need to see a physician regularly (***not just*** routine physicals)
- ☐ Yes ☐ No – I have required surgery or hospitalization
- ☐ Yes ☐ No – I have ***used or am using*** recreational drugs (e.g., cocaine)
- ☐ Yes ☐ No – I have had a "bad" reaction to a local anesthetic
- ☐ Yes ☐ No – I have had trouble with previous dental treatment
- ☐ Yes ☐ No – I have been "premedicated" prior to dental treatment
- ☐ Yes ☐ No – I am ***sensitive or allergic*** to latex rubber
- ☐ Yes ☐ No – I get (very) nervous when having dental treatment
- ☐ Yes ☐ No – I am Pregnant (Women only)

Dental Professional Notes/Additions

ATTESTATION(S) of Patient (or Surrogate for minors or legally incompetent patients)**:**
The health history information I have provided is true to the best of my knowledge.

Signature:______________________________________ **Date:**_______________

Relationship to Patient: ____