Rocklin Dental

5800 Stanford Ranch Rd. #900 Rocklin, CA 95765

Welcome

ABOUT YOU

Todays date:______________ Email Address:____

Patients Name:__________________________________ I preferred to be called:______________

Birthdate: ___/___/___ Age:_____ Social Security #:_________________________

☐Single ☐Married Spouse's Name:____

Home Address:____
Street City State Zip

Home Phone#:________________ Cell#:________________ Work#______________ ext______

Responsible Party:____ Relationship:____________

Employer:____________________ Occupation:____

Emergency Contact:_______________________________ Telephone:______________

Whom may we thank for referring you?____________________

INSURANCE INFORMATION

Primary Insurance

Insurance Co Name:_______________________________ Phone#__________________________
Address:_______________________________________ ______________ Group#______________

Insured's Name:____ Relationship:______________
Insured's Social Security #_________________________________ Insured's Birth Date: __/__/__
Insured's Employer:____

Secondary Insurance

Insurance Co Name:_______________________________ Phone#__________________________
Address:_______________________________________ ______________ Group#______________

Insured's Name:____ Relationship:______________
Insured's Social Security #_________________________________ Insured's Birth Date: __/__/__
Insured's Employer:____

Confidential Health History

Do you have a personal physician? ☐ Yes ☐ No
Physicians Name:______________________________
Address:______________________________
Street City State Zip
Phone#: (___)______________Date of Last Visit:_______
Your Current Physical health is: ☐ Good ☐ Fair ☐ Poor
Please explain:______________________________
Are you currently under the care of a physician? ☐ Yes ☐ No
____
Have there been any changes to your health within the last year?______________________________

For Women: Are you:
Taking Birth Control? ☐ Yes ☐ No
Pregnant? ☐Unsure ☐ Yes ☐ No
Week #:_______ Are you nursing? ☐ Yes ☐ No

Previous Dental Office: ______________________
Do you have any problems with prior dental treatment?
____
Are you experiencing any dental pain?______________

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codiene
Y N Darvon
Y N Dental Anesthetics
Y N Demoral
Y N Erythromycin
Y N Food
Y N Latex
Y N Metal
Y N Nitrous Oxide
Y N Penicillin
Y N Percodan
Y N Sulfa Drugs
Y N Tetracycline
Y N ValiumY N
Y N Vicodin
Y N Other

Please list additional drugs/materials that cause allergic reactions:______________________________

Are you taking or have you taken any of the following in the last three months?

Y N Acetaminophen
Y N Alcohol
Y N Antibiotics
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Meds.
Y N Digitalis/Heart Med
Y N Fosamax (Bisphosphonate)
Y N Insulin/ Diabetes Drugs
Y N Nitroglycerin
Y N Over the Counter Meds.
Y N Recreational Drugs
Y N Steroids/ Cortisone
Y N Supplements
Y N Thyroid Medicine
Y N Tobacco in any form
Y N Tranquilizers
Y N Weight Loss Medications

Are you taking any prescription/over the counter drugs not listed above? ☐ Yes ☐ No If yes, please list each one:______________________

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Autoimmune disease
Y N Blood Transfusion
Y N Bleeding Problems
Y N Blood in Urine/Stool
Y N Blurred Vision
Y N Cancer
Y N Cold Sores
Y N Chemotherapy
Y N Chest Pain (angina)
Y N Chicken Pox
Y N Chronic Pain
Y N Congestive Heart Failure
Y N Congenital Heart Defect
Y N Cosmetic Surgery
Y N Diabetes
Y N Dizziness
Y N Drug Abuse
Y N Dry Mouth
Y N Eating Disorder/Malnutrition
Y N Emphysema
Y N Epilepsy
Y N Excessive Thirst
Y N Eye Disease
Y N Fainting Spells
Y N Fever Blisters
Y N Frequent Urination
Y N Gastrointestinal Disease
Y N Glaucoma
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Scarlet Fever
Y N Seizures
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis
Y N Ulcers

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐ No
Please explain:______________________________

Is there any condition you would like to discuss with the dentist privately? ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcernia or skeletal complications resulting from Paget's disease, Multiple myeloma or metastatic cancer? ☐ Yes ☐ No

Authorizations

I have read the Dental Board of California's Dental Material Fact Sheet and Notice of Privacy Practices, and a copy has been made available to me. I, the undersigned, hereby authorize Dr. Wilson, and/or his designated employee to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Wilson to make a through diagnosis of the patient's dental needs. I also authorize the performance of any and all treatment, medication and therapy indicated based on those needs. I further authorize and consent that Dr. Wilson choose and employ such assistance as he deems appropriate. I understand that the use of anesthetic agents embodies certain risks.

I understand that responsibility of payment for dental services provided by this office for myself and/or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I agree to pay a 1-1/2 percent per month (18 percent annually) finance charge on any balance over (30) days. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I understand that my account will be debited $50 for any returned check.

I certify that I am covered by ________________________ Insurance Co. and I assign directly to Dr. Wilson all insurance benefits, otherwise payable to me. I understand that I am responsible for the timely payment of my account whether or not my insurance pays. Billing problems, the result of incorrect billing information provided me, will incur a $10.00 update/rebilling fee per claim. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electric.

If an appointment must be changed I understand a twenty four (24) hour notice is required and that I may be billed a service charge of $50.00 and up for broken or missed appointments.

Declining To Sign or Altering This Form Will Result in Rocklin Dental Being Unable To Provide Services to You
I have read the above conditions of treatment and payment and agree to their content.

_________________________________ Date: ___/___/___ Relationship to Patient:________________
Signature of patient, parent or guardian

For Office Use Only..
Health History Updates

Date	Patient Signature	Changes to Health History	Dentist Initials
__/__/__			
__/__/__			
__/__/__			
__/__/__			

Disclaimer:

Due to the changes currently being made in Dental Insurance Plans, we are strongly urging you to know the amount of your deductible or co payment, where you can be seen and the % your insurance will cover. On a daily basis our staff deals with numerous questions. They are making every attempt to keep abreast of each insurance company's rules and regulations. However you must keep in mind our ultimate goal is your dental care. Please check with your insurance company directly to verify your dental plan's covered benefits. You may contact your insurance company directly to obtain a new updated booklet regarding your dental benefits. The Dental field is ever changing; you must be a good consumer. Remember, you are responsible for your insurance coverage and their practices. Thank you for your cooperation.