Rocklin Dental
5800 Stanford Ranch Rd. #900, Rocklin, CA 95765
916.663.5555 *Office Hours* Mon-Thurs 8am-5pm, every other Friday 8am-1pm

Thank you for selecting our dental practice. Please take a few minutes to fill out this form as completely as you can. All information is confidential and will be used to help us meet your dental healthcare needs. If you have any questions or need assistance, please ask us. We will be happy to help.

Whom may we thank for referring you? _____

Patient Information

Patient Name: _____
Last First MI (Preferred Name)

Date of Birth: _____/_____/_____ Gender _____ Social Security Number _____

Address: _____CA_____
Street Apt.# City Zip Code

Phone (Home): _____ (Cell): _____ Email: _____

Emergency contact: _____ Phone # _____

Responsible Party Information

The following is for the person responsible for payment.

☐ Same as above Relationship to patient: _____

Name: _____ Birth date: _____ Social Security # _____

Phone (home): _____ (cell): _____ (work): _____

Address: _____CA_____
Street Apt # City Zip Code

I understand that I am financially responsible for all the charges to this account. I grant my permission to you to contact me at any of the above contacts to discuss matters regarding this account.

Signature _____

Patients who carry dental insurance understand that this dental office will help prepare the patients forms or assist in making collections from insurance companies. However, this dental office cannot be responsible for any balance not paid by insurance companies.

Insurance Information

Primary Insurance

Subscriber Name: _____ DOB _____

Subscriber ID # or SSN: _____

Employer: _____

Ins. Company/Carrier: _____

Plan Name: _____ Group# _____

Phone #: _____

Secondary Insurance

Subscriber Name: _____ DOB _____

Subscriber ID # or SSN _____

Employer: _____

Ins Company/Carrier: _____

Plan Name: _____ Group# _____

Phone #: _____

Patient Health information

Physician: _____ Office Phone: _____ Date of last exam: _____

Are you currently taking any medications? If yes, list all:

_____

_____

Do you have drug allergies? If yes, list all:

_____

Please Circle Y (yes) or N (no) to the following:

Have you had any serious illnesses or operations? **Y / N** If yes, pleas describe: _____

Are you under medical treatment now? **Y / N** If yes, pleas describe: _____

Have you ever had a blood transfusion? **Y / N** If yes, give approximate dates: _____

Have you ever pre-medicated for dental treatment? **Y/N** If yes, reason for pre-med_____

Have you ever had any of the following?

Y / N AIDS/HIV Positive
Y / N Anemia
Y / N Anxiety
Y / N Arthritis/Rheumatism
Y / N Artificial heart valves
Y / N Artificial joints
Y / N Asthma
Y / N Back problems
Y / N Blood disease
Y / N Cancer/Chemotherapy
Y / N Chemical Dependency
Y / N Circulatory problems
Y / N Cold Sores
Y / N Cortisone Treatments
Y / N Cough, persistent or bloody
Y / N Dental implant
Y / N Diabetes
Y / N Emphysema
Y / N Epilepsy
Y / N Fainting or dizziness
Y / N Glaucoma
Y / N Headaches, severe/frequent
Y / N Heart murmur
Y / N Heart Problems
Y / N Heart surgery
Y / N Hemophilia (abnormal bleeding)
Y / N Hepatitis – Type **A B C**
Y / N Herpes
Y / N High Blood Pressure
Y / N Jaw Pain
Y / N Kidney disease
Y / N Liver Disease
Y / N Low Blood Pressure
Y / N Material allergies
Y / N Mitral valve prolapse
Y / N Pacemaker
Y / N Psychiatric care
Y / N Radiation
Y / N Rapid weight change
Y / N Respiratory Disease
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Shortness of breath
Y / N Sinus Trouble
Y / N Special Diet
Y / N Stroke
Y / N Thyroid Problems
Y / N Tonsilitis
Y / N Tobacco habit
How often _____
Y / N Tumor/Growth on head or neck
Y / N Ulcer
Y / N Venereal Disease

Other conditions _____

Women Only: **Y / N** Are you pregnant? Due Date: _____ **Y / N** Nursing? **Y / N** Birth Control

Patient Dental Information

Reason for today's visit: _____Date of last visit: _____

Name of previous dentist: _____City: _____ Phone #: _____

Please circle if you have problems with any of the following: **Bad breath** **Food collection between teeth** **Bleeding gums** **Clicking/popping jaw** **Grinding/clenching teeth** **Sensitive teeth** **Loose teeth or broken fillings**

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever had any complications following dental treatment? _____ If yes, please explain: _____

Consent for Services

I give permission to Rocklin Dental and the clinical team to take any necessary diagnostic films, photos, or study models to efficiently enable complete diagnosis and treatment.

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I have received the Dental Board of California Dental Materials Fact Sheet, the Notice of Privacy Practices, and any other important information concerning Rocklin Dental policies. All cancellations require a 24-hour notice, or a fee may be assessed.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relation to Patient:** _____

Signature of Responsible Party