

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

Secondary Insurance

Subscriber Name: _____ DOB _____

Subscriber Name: _____ DOB _____

Subscriber ID # or SSN: _____

Subscriber ID # or SSN _____

Employer: _____

Employer: _____

Ins. Company/Carrier: _____

Ins Company/Carrier: _____

Plan Name: _____ Group# _____

Plan Name: _____ Group# _____

Phone #: _____

Phone #: _____

Patient Health History

Patient Name _____

Physician: _____ Date of last exam: _____

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

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
Are you under medical treatment now? Y / N
Have you ever had a blood transfusion? Y / N
Have you ever pre-medicated for dental treatment? Y/N

- If yes, please describe: _____
If yes, please describe: _____
If yes, give approximate dates: _____
If yes, reason for pre-med _____

Have you ever had any of the following? (within the last 5 years)

- Y / N AIDS/HIV Positive Y / N Chemotherapy Y / N Hives/Rash Y / N Shingles
Y / N Alzheimer's Disease Y / N Chest Pains Y / N Hypoglycemia Y / N Sickle Cell Disease
Y / N Anaphylaxis Y / N Circulatory problems Y / N Irregular heart beat Y / N Sinus Trouble
Y / N Anemia Y / N Cold Sores Y / N Jaw Pain Y / N Spina Bifida
Y / N Angina Y / N Congenital Heart Disorder Y / N Kidney Problems Y / N Stomach/Intestinal Disease
Y / N Anxiety Y / N Convulsions Y / N Leukemia Y / N Shortness of breath
Y / N Glaucoma Y / N Cortisone Treatments Y / N Liver Disease Y / N Special Diet
Y / N Arthritis/Rheumatism Y / N Dental implant Y / N Low Blood Pressure Y / N Stroke
Y / N Artificial heart valves Y / N Diabetes Y / N Lung Disease Y / N Swelling of Limbs
Y / N Artificial joints Y / N Drug Addiction Y / N Mitral valve prolapse Y / N Thyroid Disease
Y / N Asthma Y / N Heart murmur Y / N Osteoporosis Y / N Tonsillitis
Y / N Back problems Y / N Heart Pacemaker Y / N Parathyroid Disease Y / N Tobacco habit
Y / N Blood disease Y / N Heart Problems Y / N Psychiatric care How often _____
Y / N Blood Transfusion Y / N Heart surgery Y / N Radiation Y / N Tuberculosis
Y / N Breathing Problem Y / N Hemophilia Y / N Recent weight loss Y / N Tumor/Growth- head/neck
Y / N Bruise Easily Y / N Hepatitis - Type A B C Y / N Renal Dialysis Y / N Ulcer
Y / N Cancer Y / N Herpes Y / N Rheumatic Fever Y / N Venereal Disease
Y / N Cell Disease Y / N High Blood Pressure Y / N Rheumatism Y / N Yellow Jaundice
Y / N Chemical Dependency Y / N High Cholesterol Y / N Scarlet Fever

Other conditions _____

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

Patient Dental Information

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 agree to their content.

Date: _____ Relation to Patient: _____

Signature of Responsible Party

Dentist Signature _____

Rocklin Dental Treatment and Financial Policy

Treatment & Financial Information

- Before treatment begins, we will review your recommended care and the fees with you. This helps ensure you understand your treatment plan and can make any necessary financial arrangements in advance.
- Payment is due at the time services are provided. We accept cash, checks, CareCredit, and all major credit cards.
- New emergency patients should expect to pay at the time of service. Once you become an established active patient, we are happy to discuss additional payment options.
- If a balance remains unpaid and collection efforts are required—either through our office or a third-party collection agency—the following notice applies to any medical debt contract created on or after July 1, 2025, as required by California Civil Code § 1785.27:
 - “A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.”

Insurance Information

- As a courtesy, we will submit insurance claims on your behalf. Please bring your insurance card and employer information to each visit.
- If we are unable to verify your insurance coverage before treatment, payment will be required at the time of service.
- Any deductible or estimated co-payment is due at the time of your appointment.
- Some insurance plans reimburse patients directly. If this applies to your plan, payment will be due at the time of service, and your insurance company will reimburse you directly.
- If payment has not been received from you or your insurance company within 45 days of treatment, the remaining balance will become your responsibility

Appointment Policy

- We require at least 24 hours' notice to cancel or reschedule an appointment. Missed appointments or late cancellations will result in a \$75 fee. Appointments scheduled for two hours or longer that are missed will incur a \$200 fee. These fees are not covered by insurance.
- For separated or divorced parents of minors, the parent who brings the child to the appointment is responsible for payment of any co-payment or full fee at the time of service. If needed, we can keep a credit or debit card on file for the non-custodial parent.

Acknowledgment

- I have read and understand this financial policy.

Patient or Guardian Signature: _____

Date: _____



Dental Practice HIPAA Acknowledgment & Authorization Form

Practice Name: Rocklin Dental
Address: 5800 Stanford Ranch Rd #900
Phone: 916-663-5555 Email: rocklindentalcenter@gmail.com

Notice of Privacy Practices Acknowledgment

This dental practice complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Our Notice of Privacy Practices describes how medical and dental information about you may be used and disclosed and how you can access this information. A copy is available at our front desk and upon request.

By signing below, you acknowledge that you have received (or have been offered) a copy of our Notice of Privacy Practices.

Patient Name (Print): _____

Date of Birth: _____

Signature: _____ Date: _____

If signed by personal representative:

Name of Representative: _____

Relationship to Patient: _____

Authorization to Disclose Information (Optional)

I authorize the dental practice to disclose my protected health information to the following individuals:

Name	Relationship	Phone (Optional)
_____	_____	_____
_____	_____	_____

I understand:

- This authorization is voluntary.
- I may revoke this authorization at any time in writing.
- Revocation will not affect prior disclosures made in reliance on this authorization.

Patient/Representative Signature: _____

Date: _____

Appointment Reminders & Communication Consent

Please indicate how you prefer to be contacted (check all that apply):

- Phone (voice message allowed)
- Text message
- Email

Please indicate how you prefer to receive billing statements (check all that apply):

- Mail
- Text message
- Email

By selecting the above, I understand there is some level of risk that third parties may access these communications.

Patient/Representative Signature: _____

Date: _____