Marivic Angeles, DDS
A Professional Corporation
Gentle Family Dentist
5047 Clayton Rd. Concord, CA 94521

Today's date:_____

I. Circle Appropriate Answer

What brings you here today? _____

1. My current health is: □ Good □Fair □Poor

2. Your Previous Dentist: _____

3. Date of last dental visit: _____Date of last dental cleaning: _____#of cleanings per year: _____

4. Physician's Name: _____ Date of last medical visit? _____ Reason for visit? _____

5 Have you gone to the hospital or emergency room or had a serious illness in the past five years? □Yes □No

If yes, explain _____

II. Dental History:

□ Yes	□ No	Head or neck Injuries	□ Yes	□ No	Orthodontic treatment
□ Yes	□ No	Sore or sensitive teeth	□ Yes	□ No	Periodontal treatment (deep cleanings)
□ Yes	□ No	Bleeding gums	□ Yes	□ No	Trouble opening / closing jaw
□ Yes	□ No	Clenching or teeth grinding habit	□ Yes	□ No	Bleeding / slow healing after extraction
□ Yes	□ No	Difficulty chewing	□ Yes	□ No	Dissatisfaction with your smile
□ Yes	□ No	Anxiety towards dental treatment	□ Yes	□ No	Abnormal Bleeding
□ Yes	□ No	Hemophilia			

III. Have you had or currently have any of the following? (Please check)

□ Yes	□ No	Alcohol / Substance Abuse	□ Yes	□ No	Hepatitis A / B / C / D (Circle)
□ Yes	□ No	Anemia	□ Yes	□ No	Herpes
□ Yes	□ No	Arthritis / Joint Pain	□ Yes	□ No	High Blood Pressure
□ Yes	□ No	Artificial Heart Valves	□ Yes	□No	Immune Deficiency Syndrome HIV / AIDS
□ Yes	□ No	Artificial Joints	□ Yes	□No	Jaundice
□ Yes	□ No	Blood Transfusion	□ Yes	□ No	Kidney Problems
□ Yes	□ No	Cancer	□ Yes	□No	Liver Disease
□ Yes	□ No	Chemotherapy	□ Yes	□ No	Low Blood Pressure
□ Yes	□ No	Congenital Heart Defect	□ Yes	□ No	Pain and Clicking of the Jaws
□ Yes	□ No	Delayed healing	□ Yes	□ No	Psychiatric Treatment
□ Yes	□ No	Diabetes	□ Yes	□ No	Radiation Treatment
□ Yes	□ No	Do you smoke?	□ Yes	□No	Removable Dental Appliance
□ Yes	□ No	Dry Mouth	□ Yes	□ No	Rheumatic Fever
□ Yes	□ No	Emphysema	□ Yes	□ No	Scarlet Fever
□ Yes	□ No	Epilepsy	□ Yes	□ No	Stroke
□ Yes	□ No	Glaucoma	□ Yes	□ No	Thyroid or Parathyroid Disorders
□ Yes	□ No	Headaches	□ Yes	□ No	Tuberculosis
□ Yes	□ No	Heart Murmur	□ Yes	□ No	Ulcers
□ Yes	□ No	Heart Problems			

IV. Medication - Are you currently taking:

□ Yes	□ No	Acetaminophen	□ Yes	□ No	Any kind of natural herbal
□ Yes	□ No	Antibiotics			supplement or homeopathic remedy
□ Yes	□ No	Antihistamines	□ Yes	□ No	Heart Medication
□ Yes	□ No	Blood Thinners	□ Yes	□ No	Insulin / Diabetes Medication
□ Yes	□ No	Blood Pressure Medication	□ Yes	□ No	Steroids / Cortisone

Have you ever taken IV or Oral Bisphosphonates i.e. Fosamax, Boniva, Actonel □ Yes □ No

If yes, for how long? _____ Name of Bisphosphonates: _____

Please list other medications you are taking _____

V. Have you had any allergic reactions:

□ Aspirin / Ibuprofen	□ Sulfa Drugs	□ Latex Gloves
□ Codeine	□ Vicodin	□ Metal
□ Dental Anesthetic	□ Penicillin /Amoxicillin	□Other _____
□ Erythromycin		

VI. Do you have or had any conditions or health concerns not listed on this form? □ Yes □ No

Please list condition /s _____

Do you wish to speak to the doctor privately about anything? □ Yes □ No

VII. Women

□ Yes □ No Are you pregnant? Estimated delivery date? _____ Are you breast feeding? □ Yes □ No

□ Yes □ No Are you taking birth control pills?

I affirm that the information in the health history I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

Signature: _____ *Date*: _____ *Reviewed by*: _____

WELCOME!

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About you:

Please print legibly

Patient's name (Mr. Mrs. Ms. Dr)_____ Nickname_____

SS#: _____Birthday: _____Age: _____ Gender □ M □ F □ Other

Driver's license: _____ Payment method □ Cash □ Check □ Credit card

Address: _____ City: _____ State: _____ Zip: _____

Cell#: _____ Work#: _____ Home#: _____

Email: _____ Referred by: _____

Medical doctor: _____ Address: _____ Phone no: _____

Employed: □Yes □ No □ Full time □ Part time □ Retired
Employer: _____ Occupation: _____

Are you □ Single □ Married □ Divorced □ Separated □ Widowed □ Other

Are you a student? □ Yes □ No □ Full time □ Part time
School name and address: _____

Who will be responsible for your account: □ Self □ Spouse □ Father □ Mother □ Other
Name: _____ SS.# _____Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Phone#: _____

Spouse or guarantor information:
(*If different from above)*
Name: _____ SS#: _____Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Phone#: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Cell#: _____ Work#: _____

The practice of dentistry involves treating the whole person. If Dr.Angeles determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Dr.Angeles to contact my physician

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold this dentist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form**.**

_____

Signature of patient *Date* *Signature of dentist*

Financial Policies:

Payment is always due at the time of service. Insurance benefits provided by this office are estimates. These benefits are based on the contract between the insurance company and the employer. I understand that any balance remaining regardless of insurance is the patient or guardian's responsibility. For your convenience, we accept all major credit cards including apple pay. Fees will be assessed for the following:

Returned / bounced check	$ 50.00
Late cancellation fee (less than 48 hours)	$150.00
Collection fees	35% of balance sent to collection agency

I acknowledge that I have read and understand the financial policy above. I agree that I am responsible for all fees and services rendered. I accept full financial responsibility for all charges not covered by insurance.

Signature: _____ *Date*: _____
Signature of patient / guardian

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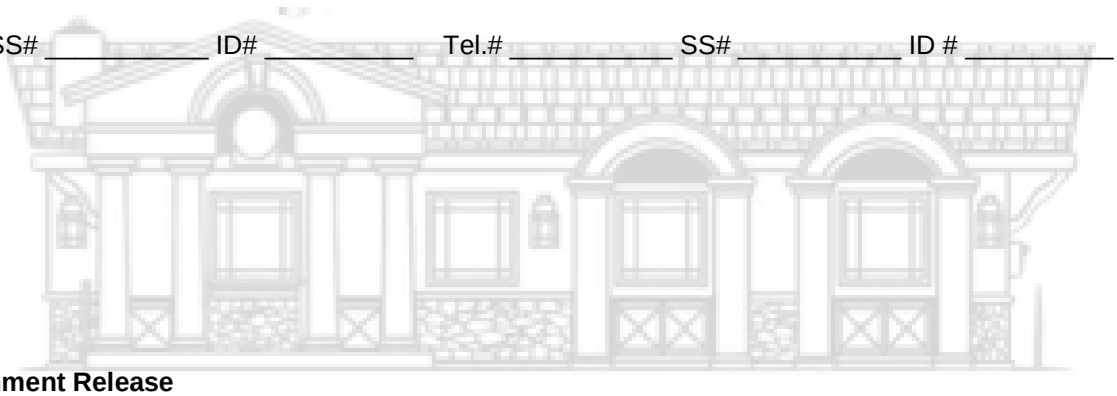
Dental Insurance Information

Primary dental coverage	Secondary dental coverage
Employer _____	Employer _____
Business Address _____	Business Address _____
Bus. Tel.# _____	Business Tel.# _____
Ins. Co. Name _____	Ins. Co. Name_____
Grp.# or name _____	Grp.# or name _____
Insured party _____ Relation _____	Insured party _____ Relation _____
Sex □ M □ F □ Other Date of birth _____	Sex □ M □ F □ Other Date of birth _____
Address of Ins Co._____	Address of Ins Co._____
Tel.# _____ SS# _____ ID# _____	Tel.# _____ SS# _____ ID # _____



Authorizations

Insurance Assignment Release

_____ This signature on file is my authorization for the release of information necessary to secure payment
signature of benefits. I authorize the use of my signature on all my insurance submissions. My consent shall remain in effect until cancelled in writing.

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HIPAA and Dental Material Fact Sheet

_____ Our office is HIPAA compliant and is committed to meeting or exceeding the standards o**f**
signature infection control mandated by OSHA, the CDC, and the ADA.
I have reviewed / received a copy of the Dental Board of California Dental Material Fact Sheet. Downloadable copies are available online or in our office for your review.