

Welcome To Our Office
Patient History & Information

Date: _____ Cell Phone#(____) _____ Referred By: _____

Patient's Name: _____ M ___ F ___
Last First MI Sex Birth Date Social Security #

Address: _____ (____) _____
Street City State Zip Home Phone

Email: _____ Employer _____

Preferred method of contact: email cell work home other _____

If over 18yrs and a full time student, name of college: _____

Spouse's Name: _____
Last First MI Birth Date

Spouse's Employer: _____ (____) _____
Work Phone

Responsible Party: _____
Last First MI Relationship To Patient

Address: _____ (____) _____
Street City State Zip Home Phone

Employer: _____ (____) _____
Name Street City State Zip Work Phone

Occupation Birth Date Social Security #

Primary Insurance Co Name: _____ Group# _____

Subscriber: _____ - - -
Last First MI Birth Date Social Security #

Employer: _____ Relationship To Patient

Secondary Insurance Co Name: _____ Group# _____

Subscriber: _____ - - -
Last First MI Birth Date Social Security #

Employer: _____ Relationship To Patient

EMERGENCY CONTACT: _____ Relationship _____ Phone _____
Last First

Please be aware of the following:

- *Antibiotics & other medications may reduce the effectiveness of oral contraceptives
- *In rare cases, patients may suffer unusual reactions to dental treatment, materials, or local anesthetic such as permanent numbness
- *Amalgam (silver) fillings contain mercury, which may pose health risks
- *I have received a copy of the CA Dental Board Dental Fact Sheet, and HIPPA disclosure
- *Patient/Responsible Parties are financially responsible for all treatment fees, regardless of insurance coverage

I consent to treatment as necessary or desirable for the well-being of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations, use of laboratory diagnostics, x-rays, laser treatment, or any other procedures that may be used by the attending doctor or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the financial department.

APPOINTMENTS CANCELLED PRIOR TO 48 HRS. OR NO SHOWS ARE SUBJECT TO A CANCELLATION FEE

Signed _____
Patient, Parent, or Agent (must be 18yrs or older)

Health History

Purpose of today's visit: Complete Examination ___ Pain ___ Broken tooth ___ Other _____
 Date of last dental exam: _____ Dentist: _____ Phone number: (____) _____
 Do you have any conditions in your mouth that concern you? ___ If so, explain? _____
 How often do you brush? _____, Use dental floss? _____ Are you worried about receiving dental treatment? _____
 Have you experienced any unfavorable reaction to previous dental treatment? _____
 Date of last medical exam: _____ Physician: _____ Phone number: (____) _____
 Is your general health good? ___ Has there been a change in your health within the last year? _____
 Have you been hospitalized or had a serious illness in the last three years? ___ Why? _____

Have you ever had a serious experience with:(circle answers)

Chest pain (angina)?	Yes	No	Dizziness?	Yes	No
Swollen ankles?	Yes	No	ringing in ears?	Yes	No
Shortness of breath?	Yes	No	Headaches?	Yes	No
Recent weight loss, fever, or night sweats?	Yes	No	Fainting spells?	Yes	No
Persistent cough, coughing up blood?	Yes	No	Blurred vision?	Yes	No
Bleeding problems, bruising easy?	Yes	No	Excessive thirst?	Yes	No
Chronic sinus problems?	Yes	No	Frequent urination?	Yes	No
Difficulty swallowing?	Yes	No	Dry mouth?	Yes	No
Diarrhea, constipation, blood in stools?	Yes	No	Jaundice?	Yes	No
Frequent vomiting, nausea?	Yes	No	Joint pain, stiffness?	Yes	No
Difficulty urinating, blood in urine?	Yes	No	Seizures?	Yes	No

Do you have or have you had:

Heart disease?	Yes	No	AIDS?	Yes	No
Heart attack, heart defects?	Yes	No	Tumors, cancer?	Yes	No
Heart murmur?	Yes	No	Arthritis, rheumatism?	Yes	No
Rheumatic fever?	Yes	No	Epilepsy?	Yes	No
Stroke, hardening of arteries?	Yes	No	Skin diseases?	Yes	No
High blood pressure?	Yes	No	Anemia?		Yes No
Asthma, TB, emphysema, lung disease?	Yes	No	Syphilis or gonorrhea?	Yes	No
Hepatitis, other liver disease? Type ___?	Yes	No	Herpes?	Yes	No
Stomach problems, ulcers?		Yes	No Thyroid, adrenal disease?	Yes	No
Diabetes?	Yes	No	Kidney, bladder disease?	Yes	No
Family history of diabetes, heart problems, tumors, high cholesterol, or gum disease?				Yes	No

Allergies to medications, foods, LATEX products, etc... Yes No

If you answered Yes please list allergies: _____

Do you have or have you had:

Psychiatric care?	Yes	No	Taken phen-fen/Redux?	Yes	No
Radiation treatments?	Yes	No	Taken Fosamax/bisphosphonates?	Yes	No
Chemotherapy?	Yes	No	Blood transfusions?	Yes	No
Prosthetic heart valve?	Yes	No	Pacemaker?	Yes	No
Artificial joint?	Yes	No	Contact lenses?	Yes	No
Do you have or have you had any other diseases NOT listed on this form?				Yes	No

If so explain: _____

Do you take: Recreational drugs? Yes No Tobacco in any form? Yes No

Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies? Yes No

Please list: _____

Women only: Are you or could you be pregnant or nursing? Yes No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's signature: _____

Date: _____

Porteous & Burke Family Dentistry
Danville 925-736-1661
Rodeo 510-799-4746

Office Financial Policy

Welcome to our Dental Office – where our team is proud to provide you superior dental care at reasonable fees. Feel and look your very best through our excellent dental care. Be confident in your care knowing we are committed to your treatment being successful. Please understand that payment of your services is considered part of your treatment. Because of this, we have adopted a simple financial policy for ALL of our patients. Please read and sign this policy prior to any treatment being started.

- 1.) All patients must complete our patient information forms before seeing the doctor for treatment.
 - 2.) **Full payment is due at the time of service.**
 - 3.) If you have dental benefits (a.k.a. insurance), your portion and deductible for your dental treatment will be due at the time of service.
 - 4.) We accept cash, check, credit cards, and Care Credit.
 - 5.) We offer the following for our self-pay patients:
 - 5% senior courtesy for patients 65 and older if dental visit poses a financial hardship.**
 - 5% reduction in fee for self-pay patients who pre-pay their treatment in full by cash, check, or credit card at least one week or more before their scheduled appointments. **
- **Only one courtesy may apply for any given patient or procedure.**
- 6.) Parents (or legal guardian) are responsible for payment for minor children at the time of service.
 - 7.) In the rare event that your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for all collection costs, reasonable attorney fees, and court fees incurred by this office.

INSURANCE

If you belong to a traditional insurance plan, our team can assist you by filing your insurance claim as a benefit to you. However, please be prepared to pay any patient portions and/or deductibles in full at the time of service. Be aware that the balance incurred at our office is your personal responsibility regardless of your insurance company's payment and coverage. Coverage amounts vary from policy to policy, and it is your responsibility to seek coverage amounts and limits of liability on your insurance policy. Please understand that your insurance policy is a contract between you and your insurance company. Dr. Porteous holds no party to that contract and will not be responsible in the event your insurance company denies any claim. **Please note:** Laboratory Fees or the costs of precious metal are added costs that apply to treatment involving laboratory work. These and other upgrades will appear on your treatment estimate. Nitrous Oxide is also offered in our office and may not be covered by your insurance. We offer this service for your comfort.

Thank you for choosing Porteous & Burke Family Dentistry as your dental provider and for understanding our “Financial Policy”. Please bring your insurance information with you at time of your appointment.

Appointments cancelled prior to 48 hours without notice and No Shows are subject to a fee.

Signature of Responsible Party: _____ Date _____