WALNUT FAMILY DENTAL

Patient Registration

PATIENT INFORMATION

Name_____
Last First MI Preferred Name

Address _____

City_____ State_____ Zip_____

Phone _____Soc. Sec # _____

Sex: ☐Male ☐Female Age: _____ DOB _____ ☐Single ☐ Married ☐Child

Email_____Driver License #_____

Emergency Contact _____ Phone _____

Employment Status ☐ F/T ☐P/T ☐Retired Student Status ☐F/T ☐P/T

PRIMARY INSURANCE

Person Responsible for Account_____
Last First MI

Relationship to Patient_____ DOB _____ SS # _____
(If different then patient)

Address_____Phone _____

City_____State_____ Zip_____

Insurance Co_____ Member ID _____ Group# _____

SECONDARY INSURANCE

Person Responsible for Account _____
Last First MI

Relationship to Patient_____ DOB _____ SS # _____
(If different then patient)

Address_____Phone _____

City_____State_____ Zip_____

Insurance Co_____ Member ID _____ Group# _____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist _____ Date of Last Dental Care _____

How often do you floss? _____ How often do you floss? _____

Check if you have had problems with any of the following:

☐ Bad Breath
☐ Bleeding
☐ Clicking or Popping Jaw
☐ Food Stuck in between Teeth
☐ Grinding Teeth
☐ Loose teeth or Brocken Fillings
☐ Periodontal Treatment
☐ Sensitivity

Although dental personnel primary treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions

MEDICAL HISTORY

Are under a physician's care now? Yes No
If yes _____

Have you ever been hospitalized or had a major operation? Yes No
If yes _____

Have you ever had a serious head or neck injury? Yes No
If yes _____

Are you taking any medication, pills, or drugs? Yes No
If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No
If yes _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? Yes No
If yes _____

Are you on a special diet? Yes No
If yes _____

Do you use tobacco? Yes No
If yes _____

Women: Are you

☐Pregnant/Trying to get pregnant ☐Nursing ☐Taking oral contraceptive

Are you allergic to any of the following?

☐ Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthesia ☐Ibuprofen

Do you use controlled substances? ☐Yes ☐No If yes _____
Other? ☐ If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes ☐No	**Cortisone Medicine**	☐Yes ☐No	**Hemophilia**	☐Yes ☐No	**Radiation Treatment**	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	**Diabetes**	☐Yes ☐No	**Hepatitis A**	☐Yes ☐No	**Recent Weight Loss**	☐Yes ☐No
Anaphylaxis Anemia	☐Yes ☐No	**Drug Addiction**	☐Yes ☐No	**Hepatitis B or C**	☐Yes ☐No	**Renal Dialysis**	☐Yes ☐No
Angina Arthritis/Gout	☐Yes ☐No	**Easily Winded**	☐Yes ☐No	**Herpes**	☐Yes ☐No	**Rheumatic Fever**	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	**Emphysema**	☐Yes ☐No	**High Blood Pressure**	☐Yes ☐No	**No Scarlet Fever**	☐Yes ☐No
Artificial Joint Asthma	☐Yes ☐No	**Epilepsy or Seizures**	☐Yes ☐No	**High Cholesterol**	☐Yes ☐No	**Shingles**	☐Yes ☐No
Blood Disease	☐Yes ☐No	**Excessive Bleeding**	☐Yes ☐No	**Hives or Rash**	☐Yes ☐No	**Sickle Cell Disease**	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	**Fainting Spells/**	☐Yes ☐No	**Hypoglycemia**	☐Yes ☐No	**Sinus Trouble**	☐Yes ☐No
Breathing Problems	☐Yes ☐No	**Dizziness**		**Irregular Heart Beat**	☐Yes ☐No	**Spina Bifida**	☐Yes ☐No
Bruise Easily	☐Yes ☐No	**Frequent Cough**	☐Yes ☐No	**Kidney Problems**	☐Yes ☐No	**Stomach/Intestinal**	☐Yes ☐No
Cancer Chemotherapy	☐Yes ☐No	**Frequent Diarrhea**	☐Yes ☐No	**Leukemia**	☐Yes ☐No	**Disease**	☐Yes ☐No
Chest Pains Cold sores	☐Yes ☐No	**Frequent Headaches**	☐Yes ☐No	**Liver Disease**	☐Yes ☐No	**Stroke**	☐Yes ☐No
/ Fever Blisters		**Genital Herpes**	☐Yes ☐No	**Low Blood Pressure**	☐Yes ☐No	**Swelling of Limbs**	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	**Glaucoma Hay Fever**	☐Yes ☐No	**Lung Disease**	☐Yes ☐No	**Thyroid Disease**	☐Yes ☐No
Convulsions	☐Yes ☐No	**Heart Attack/Failure**	☐Yes ☐No	**Mitral Valve Prolapse**	☐Yes ☐No	**Tonsillitis**	☐Yes ☐No
Yellow Jaundice	☐Yes ☐No	**Heart Murmur**	☐Yes ☐No	**Osteoporosis**	☐Yes ☐No	**Tuberculosis**	☐Yes ☐No
		Heart Pacemaker	☐Yes ☐No	**Pain in jaw Joints**	☐Yes ☐No	**Tumors or Growths**	☐Yes ☐No
		Hear Trouble/	☐Yes ☐No	**Parathyroid Disease**	☐Yes ☐No	**Ulcers**	☐Yes ☐No
		Disease		**Psychiatric care**	☐Yes ☐No	**Venereal Disease**	☐Yes ☐No

Have you ever had any serious illness not listed? ☐Yes ☐No If yes _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ **Date:** _____

Financial and Office Policy

Thank you for choosing Walnut Family Dental. Our primary mission is to deliver the best and most comprehensive dental care available to you. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Check, Apple Pay, Visa, Discover, MasterCard, American Express, Care Credit are accepted.
  NOTE: Walnut Family Dental charges $35 for returned checks
- We offer a 5% courtesy accounting adjustment for ***NO INSURANCE PATIENTS** who pay for treatment in full over $500 or more. **(*excludes specialty services and care credit payments**)
- Special financing options with convenient monthly payments are available through Care Credit healthcare credit card. No interest and extended payments are available on approved credit by Synchrony Bank.
- Walnut Family Dental requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- In the case of divorce or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatment begins. Therefore, the parent authorizing treatment for a child will be the parent responsible for those charges regardless of which parent is the guarantor of the dental insurance plan.
- For larger, more comprehensive treatment plans of $1,000 or more, a deposit of 20% may be required. For appointments with our specialist, a $125 deposit will be required to secure your appointment due to limited availability regardless of the treatment cost.

Records: Records can be provided upon written request. A $.25 per page fee may apply prior to receiving records.

Insurance: For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. Although we may estimate your insurance benefits, **WE ARE NOT RESPONSIBLE FOR THEIR ACCURACY**. You are responsible for all non-covered services, along with deductibles and copayments. You are responsible to provide our office with any changes in coverage as well as provide the insurance company with any information they may request to process your claim. Your insurance is an agreement between you and the insurance company; ultimately, you are responsible for all charges. Any accounts with past due balances will be sent to a third party for collection.

Appointments: Please help us serve you better by keeping scheduled appointments. We require at least 24-48 hour notice for cancellation. After 2 missed appointments or cancelled appointments, we will place you on the short call list. You will be contacted when an appointment becomes available. (A $50 charge may apply for missed appointment and /or for cancellation of appointments on the same day of reserved time. **NOTE**: We reserve the right to terminate professional Dentist-Patient relationship.

Print Patient Name:_____ Date: _____

Signature of Patient, Parent or guardian: _____

330 N. Lemon Ave. Walnut, CA. 91789909.594.9444 Walnutfamilydental@gmail.com

INFORMED CONSENT FOR RADIOGRAPHS (X RAYS)

This office follows the guidelines of the American Dental Association and recommends that a Full Mouth X-ray (FMX)/ Panoramic X-ray be taken once every 3-5 years and Bitewings X-rays every year for routine cases.

*Current x-rays will be necessary before any diagnosis can be finalized. **NO TEETH WILL BE EXTRACTED** without a current x-ray. **NO TREATMENT** will be performed without current X-rays.

*Children and Adults, if any decay or dental infection (abscess) is present in a visual exam, x-rays will be necessary to assess the extent of the damage to the tooth structure. If your child is uncooperative, we will refer you to a Pediatric Dentist for treatment.

*Pregnant Women X-RAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform this office if you think you might be pregnant and the X-ray will be postponed.

X-rays are needed to help diagnose, here are a few examples
1) Bone loss associated with **Periodontal Disease**
2) Decay in between the teeth
3) Integrity of root canal fillings
4) Impacted teeth (Panoramic X-ray)
5) Need for orthodontic treatment

RADIATION EXPOSURE: This office uses digital x-rays, which minimizes your exposure. The amount of exposure from a FMX (18 Films) associated with dentistry represents a minor contribution to the total exposure from all sources, including natural and manufactured (man-made). (ADA.org) for more info.

I HAVE READ, UNDERSTOOD, AND CONSENT TO HAVING X-RAYS TAKEN IN THIS OFFICE.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

I REFUSE TO HAVE XRAYS TAKEN AT THIS TIME. I UNDERSTAND THAT A COMPLETE AND THOROUGH DIAGNOSIS IS NOT POSSIBLE. I WILL NOT HOLD THE DENTIST OR WALNUT FAMILY DENTAL RESPONSIBLE FOR NOT INFORMING ME OF ANY OF THE CONDITIONS LISTED ABOVE.

WE RESERVE THE RIGHT TO TERMINATE TREATMENT OR INCOMPLETE RECORDS

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 **(HIPAA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from my Dental Insurance for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date: _____

Signature:_____Relationship to Patient:_____

_____

_____

AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Under the requirements for **H.I.P.A.A**. we are not allowed to disclose this information to anyone without the patient's consent, even if you are the Spouse, Insurance holder, Legal Guardian or Parent of anyone 18+, emancipated minors, minors who can legally consent for services without Guardian or Parental consent or notification. If you would like to have your dental conditions and/or dental treatment disclosed, please indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ You May Disclose My Information to the Following ☐ Do Not Disclose My Information to Anyone But Me

1. _____Relationship to Patient: _____ Date: _____

2. _____Relationship to Patient:_____ Date: _____

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: ☐ The patient refused to sign ☐Communication Barriers ☐ Emergency Situation

Electronic Prescription Form

First Name:_____

Middle Name: _____

Last Name:_____

Date of Birth:_____Gender: _____

Address:_____

City:_____State:_____ Zip Code:_____

Phone Number:_____☐Cell ☐ Home ☐Work Allergies, Drug name and

Reaction:_____

Completed Pharmacy Information is required to submit electronic prescription

Pharmacy Name:_____

Pharmacy Phone Number:_____

Address: _____

City:_____ State_____Zip Code:_____

For Kaiser Members

Member ID#:_____

For Patients 18 and under:

Height:_____Weight: _____

Signature:_____Date: _____