WELCOME

UPTOWN DENTAL GROUP

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 Patient Information

Patient's Last Name _____ First _____ MI _____

I prefer to be called: _____ ❑Male ❑Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____ Apt./Condo # _____

City _____ State/Zip _____ How Long? _____

Marital Status: _____

Home #: _____ **Cell #:** _____

Wk #: _____ D.L. #: _____

E-Mail Address: _____

Person Responsible for Account

if patient is a minor: _____ Name

Home #: _____ Cell #: _____

Wk #: _____ Other #: _____

Billing Address (if different): _____

Relationship: _____ S.S. #: _____

Birthdate: ___/___/___ D.L. #: _____

Employer (Patient, Parent or Guardian): _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we Thank for referring you? _____

Other family members seen by us?: _____

Previous / Present Dentist: _____

Last Visit Date: _____ Why did you leave? _____

_____

2 Spouse Information

Name: _____

Employer: _____

Occupation: _____ Years with firm _____

Wk #: _____ S.S. #: _____

Birthdate: ___/___/___ D.L. .#: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's S.S. #: _____

Yearly Deducible $_____ Max. Annual Benefit $_____

I realize that this may not represent the full payment for services rendered and I will be responsible for any balance due.

Secondary Dental Insurance

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___/___/___ Insured's S.S. #: _____

Yearly Deducible $_____ Max. Annual Benefit $_____

Our policy allows six weeks for insurance payment at which time you will be billed directly.

In case of emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Cell #: _____ Hm #: _____

4 Medical History

Do you have a personal physician? ❑ No ❑ Yes

Physician's Name: _____

Phone #: _____ Date of last exam: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain: _____

Patient's Medical Specialist: _____ (if under present care)

Phone: ( ) _____

Are you taking or scheduled to begin taking either of the medications Alendronate (Fosamax®) or Risedronate (Actonel®) for Osteoporosis or Paget's Disease? ❑ No ❑ Yes

Are you taking any over-the-counter drugs? ❑ No ❑ Yes

Please list each one: _____

For Women: Are you taking birth control pills? ❑ No ❑ Yes

Are you pregnant? ❑ No ❑ Yes Possibility of Pregnancy? _____

Are you nursing? ❑ No ❑ Yes Month #: _____

Continued on back of form ⇨

4 MEDICAL HISTORY - *continued*

Have you ever had any of the following diseases or medical problems? *(Please Circle)*

Y N AIDS
Y N HIV Positive
Y N Anemia
Y N Fainting
Y N Arthritis
Y N Rheumatism
Y N Artificial Heart Valves
Y N Artificial Prosthesis
Describe _____
Y N Asthma
Y N Back Problems
Y N Excessive Bleeding
Y N Blood Transfusion
Y N Cancer
Y N Chemical Dependency
Y N Circulatory Problems
Y N Hemophilia
Y N Cortisone Treatments
Y N Diabetes
Y N Malignancies
Y N Emphysema
Y N Glaucoma
Y N Epilepsy
Y N Cerebral Palsy

Y N Seizures
Y N Radiation Treatment
Y N Headaches
Y N Heart Murmur
Y N Dizziness
Y N Heart Problems
Describe _____
Y N Hepatitis
Y N Nephrosis
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Kidney Disease
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Nervous Problems
Y N Pacemaker
Y N Stroke
Y N Psychiatric Care
Y N Respiratory Disease
Y N Rheumatic Fever
Y N Shingles
Y N Scarlet Fever
Y N Thyroid Problems

Y N Tobacco Habit
Y N Tonsilitis
Y N Tonsils Out
Y N Tuberculosis
Y N Ulcer
Y N Chronic Sinus
Y N Venereal Disease
Y N Mumps
Y N Chicken Pox
Y N Herpes
Y N Allergies
Y N Hives
Y N Measles
Y N Adenoids Out
Y N Jaundice
Y N Mastoid
Y N Ear Infection
Y N Pain in Region of Ears
Y N Congenital Heart Problems
Y N Diseased Induced Heart Problems
Y N Osteoporosis
Y N Other _____

Please describe any current medical treatment, including **prescription drugs**, impending operations, pregnancies, or other medical information of which the doctor should be aware that has not been asked. _____

Pharmacy Phone # _____

Have you allergic reactions to any of the following drugs:

Y N Penicillin
Y N Aspirin
Y N Erythromycin
Y N Tetracycline
Y N Local Anesthetics
Y N Codeine
Y N Mercury
Y N Latex
Y N Nickel

Please list any other drugs that you have allergic reaction to: _____

5 DENTAL HISTORY

Y N **Do you prefer to save your teeth?**

On Your Previous dental visits :

Y N Were you given a local anasthetic?
Y N Were X-rays given?
Y N Were home instructions given?
Y N Were regular preventive visits made?
Y N Was there a history of dental decay?
Y N Were there any special problems?:
Y N Do you dislike the looks of your teeth?

Do you have a history of:

Y N Nail biting
Y N Hard swallowing
Y N Mouth breathing
Y N Biting hard objects
Y N Grinding teeth
Y N Sores or growths in your mouth
Y N Loose teeth
Y N Ortho. work

Is there a sensitivity in your mouth to:

Y N Heat
Y N Cold
Y N Sweets
Y N Biting
Y N Chewing
Y N Previous injury

5 DENTAL HISTORY - *continued*

Why have you come to the dentist today? _____

Date of last mouth X-ray _____

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

How long do you use a toothbrush before replacing it? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, how? _____

I CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. i will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. **It is my obligation to report any changes on health or medications I may take.**

_____
Patient, Parent or Guardian Signature Date

!

For us, to help you have a great smile is our continuous goal. Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is commited to meeting or exceeding the standards of infection control mandated by O.S.H.A., HIPAA, the CDC and the ADA.

I verbally reviewed the medical / dental information above with the patient named herein. Initials ____ ____ Date ____ ____ ____ ____

Doctor's Comments: _____

Medical History Update

1. I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature Date
2. I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature Date
3. I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____ Signature Date

UPTOWN 6711 S. Greenleaf Avenue
DENTAL Whittier, California 90601
GROUP Telephone (562) 698-0054

Welcome to our dental practice. We are pleased to have the opportunity to help you improve and maintain your oral health.

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment.

Full payment is due at time of service. We accept Cash, Checks, Visa/Master card, American Express or Discover. We offer an Extended Payment Plan with prior credit approval (through Care Credit).

Regarding Insurance

We may accept assignment of insurance benefits after your second visit. However, we do require 50% of the bill to be paid at time of service. ***The balance is your responsibility whether your insurance company pays or not.*** We can not bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. If your insurance company has not paid your account in full within 45days, the balance will be automatically billed to you. Balances older than 60 days may be subject to additional ***collection fees of $40.00 and interest charges of 1.50 % per month***. Please be aware that some, and perhaps, all of the services provided may be non-covered services and not considered reasonable by your insurance policy.

Regarding insurance plans where we are a participating provider, ***all co-pays and deductibles are due at time of treatment***. In the event that your insurance coverage changes to a plan were we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of services.

Minor Patients

The adult accompanying a minor and the patients (or guardians of the minor)are responsible for full payment. Minor unaccompanied by an adult, treatment will be denied, so please make arrangements to send your children to their appointments with an adult and you should have dental charges pre-authorized to an approved credit plan. Visa/Master card, or payment by cash or check at time of service. Please present payment to the receptionist before seeing the dentist.

Missed Appointments

Unless canceled, at least ***2 business days*** in advance during office hours for Specialist or 1 day for General Dentist, our policy is to charge for every missed appointment ***$20.00 per each half hour*** and for ***Specialist appointments there is a $40.00*** charge for each half hour. Please help us serve you better by keeping scheduled appointments. Cancellations left on answering machine are not accepted.

Thank You for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

_____ **Date**_____

Signature of Patient or Responsible Party

6711 Greenleaf Avenue
Whittier. CA 90601
562/698-0054

Uptown Dental Group

Insurance Patient Responsibility Form

I understand that the services I receive will be billed to my insurance. In the event that my insurance denies benefit for any of the services., I am responsible for the charges on the treatment rendered. I also understand that the fees collected from me are an **estimate** of my share of the cost for my dental treatment. Since it is an estimate, I understand that in the event that the insurance pays less then estimated I would pay the difference.

Signature of Insured person/Responsible party Date

Patient name Witness Date