MINOR PATIENT INFORMATION

(PLEASE PRINT)

Date_____

Patient's Name: Last_____ **First**_____ **MI** ___ **Preferred**_____

Sex: □**Male** □**Female** **Date of birth**_____ **Age**_____ **Grade** _____ **School**_____

Address: Street_____ **City**_____ **Zip Code**_____

Email Address:_____ **Home Phone**_____-_____-_____ **Cell Phone** _____-_____-_____

FATHER / Guardian's Name: (Last, First, MI) _____

Marital Status: □**Married** □**Single** □**Divorced** □**Other** **Date of Birth**_____

SSN#_____ **Driver License#**_____ **Occupation**_____

Address: Street_____ **City**_____ **Zip code** _____

Email Address_____

Home Phone _____-_____-_____ **Work** ____-____-_____ **Cell** ____-____-_____

MOTHER / Guardian's Name: (Last, First, MI) _____

Marital Status: □**Married** □**Single** □**Divorced** □**Other** **Date of Birth**_____

SSN#_____ **Driver License#**_____ **Occupation**_____

Address: Street_____ **City**_____ **Zip code** _____

Email Address_____

Home Phone _____-_____-_____ **Work** ____-____-_____ **Cell** ____-____-_____

Person filling out paperwork: Name_____ **Relationship to the patient**_____

Responsible person for account _____ **Relationship to the patient**_____

Who will be in charge of making appointments? _____

Phone Numbers _____ **Email address** _____

Notify in case of emergency_____ **Address** _____

Phone Numbers _____ **Email address** _____

How did you hear about us? _____

MEDICAL QUESTIONNAIRE / HEALTH HISTORY

Patient's Name_____ Height_____ Weight_____
Physician's Name_____ Phone_____
Address_____ Date of last visit_____
Have you had a serious illness or injury in the past year? □□Yes □No
Please explain_____
Please list any medications you are now taking and their purpose:
_____
_____
_____
Are you allergic to any medications? □□Yes □No If YES, please list below:
_____

Do you now have or have you ever had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Chest pain	☐	☐	Headaches, migraines	☐	☐	Blood disorders
☐	☐	Heart disease	☐	☐	Nervousness/anxiety	☐	☐	Bruise easily
☐	☐	Heart attack	☐	☐	Diabetes	☐	☐	Fainting or dizziness
☐	☐	Heart surgery	☐	☐	Arthritis/rheumatism	☐	☐	Hepatitis □A □ B □C
☐	☐	Stroke	☐	☐	Artificial joints	☐	☐	Liver disease
☐	☐	High blood pressure	☐	☐	Swollen/painful joints	☐	☐	Sinus trouble
☐	☐	Heart pacemaker	☐	☐	Osteoporosis	☐	☐	Venereal disease
☐	☐	Congenital heart lesions	☐	☐	Kidney trouble	☐	☐	Herpes
☐	☐	Heart murmur	☐	☐	Ulcer	☐	☐	Cold sores/fever blisters
☐	☐	Mitral valve prolapse	☐	☐	Tuberculosis	☐	☐	Glaucoma
☐	☐	Artificial heart valve	☐	☐	Persistent cough	☐	☐	Thyroid problems
☐	☐	Rheumatic fever	☐	☐	Emphysema	☐	☐	Cancer
☐	☐	Anticoagulant therapy	☐	☐	Asthma	☐	☐	Tumor or growth
☐	☐	Chemical dependency	☐	☐	Hay fever	☐	☐	Radiation treatment
☐	☐	Epilepsy or seizures	☐	☐	Allergies/hives	☐	☐	Chemotherapy
☐	☐	Auto immune disease	☐	☐	Bulimia/anorexia/diet	☐	☐	HIV+ /AIDS
☐	☐	Cortisone medication	☐	☐	Tobacco habit	☐	☐	Surgical implants
☐	☐	Latex sensitivity	☐	☐	Psychiatric/psychological care			

Have you ever taken prescription medication for weight loss (diet pills)? (Fen-Phen, Redux, Other) □Yes □No
Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drug? □Yes □No
For women only: Are you pregnant? □Yes □No Nursing? □Yes □No Are you taking birth control pills? □Yes □No

Do you snore? □Yes □No Have you ever been diagnosed with Obstructive Sleep Apnea? □Yes □No
Have you been told you need a C-Pap? □Yes □No

Is there anything else concerning your health not listed above? □Yes □No If YES, please list below:
_____
_____

Doctor's signature: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.
I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient/Parent Signature_____Date_____

DENTAL QUESTIONNAIRE/PRECLINICAL INTERVIEW

Patient's Name_____

What do you expect from your visit with us today?

_____

Do you have any dental problems that you are aware of?

_____

On a scale of 1-10 (10=highest), how would you rate your dental health and why?

_____

What would you like your teeth to be like in 10 to 20 years?

_____

Former dentist _____Last dental visit/reason_____
Last dental cleaning_____ Date of last set of x-rays_____
How do you feel about your last dentist?_____
Past dental work? _____
Wisdom teeth extracted? □Yes □No Any difficult extraction in the past? □Yes □No Prolonged bleeding? □Yes □No
Did you wear braces? □Yes □No If yes, how long ago?_____
Do you currently have orthodontic retainers? □Yes □No Do you wear them? □Yes □No
Have you worn a bite plate or any other appliance? □Yes □No Has your bite ever been adjusted? □Yes □No
Do you wear dentures or partials? □Yes □No If yes, date of placement _____
Food collection between teeth? □Yes □No Loose teeth or broken fillings? □Yes □No
Sensitivity to cold/hot/sweets? □Yes □No
Sensitivity or pain to biting/chewing? □Yes □No
How often do you brush? _____Type of brush?_____ Bad Breath? □Yes □No
How often do you floss?_____
Bleeding gums? □Yes □No Periodontal treatment in the past? □Yes □No
What do you know about periodontal disease?

_____

Are you aware that there are medical conditions related to dental disease?

_____

Do you clench or grind? □Yes □No Joints (TMJ) click or pop? □Yes □No
Jaws tired? □Yes □No Difficulty in opening, closing, chewing? □Yes □No
Have you had any head, neck or jaw injuries? □Yes □No
Do you have any sores or lumps in your mouth or near? □Yes □No
Are you allergic to or have you had any reaction to local anesthetic (like novocain)? □Yes □No
If you could improve anything about your smile, what would it be?

_____

How do you feel about the appearance of your teeth?

_____

Do you experience any apprehension before or during dental visits? □Yes □No If so please explain:

_____

Please feel free to let us know how we can help make your dental experience with us more pleasant.

_____

I hereby authorize the doctor and/or designated staff to take x-rays, photographs, study models and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. **Initials**_____

Patient/Parent Signature_____ Date_____

1101 Maidu Drive ● Suite 100 ● Auburn ● CA 95603 ● (530) 823-8771 ● Fax (916) 668-5961 ● www.maidudental.com

OFFICE GUIDELINES

Thank you for selecting us to be your personal dental care team.
Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Please feel free to let us know if you have any questions or concerns.

In order to keep our fees as low as possible, we ask that payment be made at the time of service. For your convenience, we will provide you with an estimate of cost for treatment prior to your appointment which will give you the opportunity to plan in advance for your dental care.
For your convenience we offer a variety of payment options to help you receive the quality dental care that you need. Please identify which form of payment is most convenient for you at the time of service.
Cash/ Check _____ ATM _____ Visa/MasterCard _____ American Express_____ Extended Payment Options _____
Returned checks will result in a $25.00 servicing fee to your account. Only cash or credit card payments will then be accepted. ***Initials_____***

Accounts are considered PAST DUE if there is an applicable balance owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 60 days, or the account has been sent to collection. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60-days are subject to a $25 rebilling fee per month. Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay required these fees to be incurred. ***Initials_____***

We will make every attempt to provide convenient appointment times for you within our normal business hours. We respect your time and will make every effort to begin your dental appointment on time. We will provide you with estimated appointment lengths so you may plan your day appropriately. So we may properly treat you, we ask that you arrive for your appointment as scheduled. If you are unable to keep an appointment that has been reserved for you, we ask for 2 business days notice of your need to reschedule. Otherwise a **$75** broken appointment fee will apply and we will require a credit card to reserve future appointments. Early notification will allow us to offer you a more convenient appointment and to offer your previously reserved time to another patient. We realize that emergencies do occur and we will be flexible under those circumstances. ***Initials_____***

I authorize the dentist to release any information (e.g. the diagnosis and the records of any treatment and examination rendered to me during the period of such dental care) to third party payers and/or health practitioners.
I give permission for any photographs and/or diagnostic images to be used in professional presentations or journals. ***Initials_____***

My signature indicates that I understand that policies outlined and any questions I have with regards to office policies have been answered.

Print Name_____

Signature_____ Date_____

I have received a copy of the Dental Materials Fact Sheet. ***Initials_____***

I have received a copy of the Notice of Privacy Practices Form. ***Initials_____***

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insured: Last _____ First _____ MI ___

Is insured a patient in our office? ☐ Yes ☐ No

Insured's date of birth: _____ ID# or SSN#_____

Insured's Address: Street: _____City: _____ Zip code: _____

Insured's Employer Name: _____

Address: Street: _____City: _____ Zip code: _____

Patient's relationship to insured/ subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company Name: _____

Address: _____

Phone # _____ Fax # _____Group # _____

SECONDARY INSURANCE:

Name of Insured: Last _____ First _____ MI ___

Is insured a patient in our office? ☐ Yes ☐ No

Insured's date of birth: _____ ID# or SSN#_____

Insured's Address: Street: _____City: _____ Zip code: _____

Insured's Employer Name: _____

Address: Street: _____City: _____ Zip code: _____

Patient's relationship to insured/ subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Company Name: _____

Address: _____

Phone #_____ Fax # _____Group #_____

OVER

We are always happy to assist our patients with receiving their maximum benefits from their insurance carrier. It is our feeling that the term "dental insurance" can be very misleading. What is commonly known as dental insurance can more accurately be termed **dental benefits**. In general, dental benefits are not intended to pay for **all** treatment. Rather, dental benefits assist with treatment costs. This explains why most benefit plans cover a percentage of each procedure and limit patients to a maximum annual benefit. Individual dental insurance companies establish their own criteria for coverage, their own fee schedule and determine the percentages paid.

While we are not a contracted provider with insurance carriers, we work with most insurance carriers to ensure that our patients receive the benefits to which they are entitled.
As a courtesy to you we will complete insurance information forms and submit claims on your behalf. This will save you time and facilitate payment to our office from your insurance company.
We will cooperate fully with the regulations and requests of your insurance company and we will work with you and your carrier to assist you in obtaining your reimbursement for rendered dental services.

We also must emphasize that as your dental care provider, our relationship is with **you**, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. All charges you incur are your responsibility regardless of your insurance coverage. Our office does not guarantee that your insurance company will pay for treatment you receive in our practice.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your **estimated** co-payment may be adjusted after the time of service depending upon the final reconciliation of the insurance benefit payment. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. We also offer no interest payment plans.

You will receive a statement if there is a balance due on your account, even though an insurance claim has been filed, since **you** are ultimately responsible for payment on your account.
Insurance payments ordinarily are received within 30-60 days from the time of billing. **If payment from your insurance company is not received within 60 days from date of service, we will ask you to pay the balance in full at that time.**
A late charge of **$25** will be applied every month to accounts with outstanding balances that are past due 60 days or longer.

I authorize the insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that if my insurance company doesn't pay the estimated dental benefits for ANY reason (such as age limitations, frequency clauses, annual maximums, deductibles, etc) I am responsible for the payment.

Print Name: _____

Signature: _____Date: _____

Relationship to patient: _____