Patient Details

Last Name | First Name | Middle Initial | Social Security #

Home Phone Number | Cell Phone Number | Work Phone Number

Street Address | City | Zip Code

Date of Birth | Email Address

Insurance Information

Person Responsible for Account | Address (if different) | Relationship to Patient

Employer | Address | Occupation

Dental Insurance Plan | Group Number | Employee I.D Number

Spouse's Employer | Address | Occupation

Spouses Insurance Plan | Group Name | Employee I.D Number

In Case Of An Emergency Who Should Be Notified? | Phone Number

I authorize Crestview Dental Group to perform dental examinations, diagnostic and treatment procedures that his judgement may indicate for this patient based upon the information provided.

I also authorize release of information to my insurance carrier(s). I authorize insurance payment directly to Dr. Wallis and I understand that I am responsible for my bill, as well as, knowing my insurance benefits and limitations.

Patient or Patient/ Guardian | Date

Signed:

Dental Information

Please Answer The Questions Below: **CHECK ONE:**

1. Do you have any concern or questions about the comfort, function, or appearance of your teeth? YES NO

Please Specify: ____

2. Do you have pain in or near your ears or frequent headaches? YES

NO

3. Do you clench or "grind" your teeth during the night or day? YES NO

4. Have you experienced any unfavorable reaction or result from previous dental treatment? YES NO

Please Specify: ____

Are you in pain now?____

5. What is the approximate date of your last dental visit? ____________________________

6. Is there anything that bothers you about dental treatment? __________________________

Please Specify:____

We Want To Get To Know You!

Please answer the following question to help US help YOU!

1. What is the best way to get in contact with you?

Phone Call Text Message Email Other:________________

2. If you had only ONE word to describe yourself what would it be?

____

3. Aside from necessities, what could you not go a day without?

____

4. What genre of music do you like to listen to? (you can circle more than one)

Pop Jazz Hip-Hop Indie R&B

Country Latin Classical Blues Rock

Health History

Please Circle The Appropriate Answer (Leave Blank If You Do Not Understand The Question)

YES NO Is your general health good?
YES NO Has there been a change in your health within the last year?
YES NO Have you been hospitalized or had a serious illness in the last five years? If yes, why?
____
YES NO Are you being treated by a physician now? If yes, why?________________
What was the approximate date of your last medical exam? ________________
YES NO Have you ever taken the weight loss medication Fen-Phen or Redux?
YES NO Are you using any recreational drugs?
YES NO Are you using any form of tobacco? If so, are you interested in quitting tobacco? YES NO
YES NO Do you drink carbonated beverages? If so, how many per week?____________
YES NO Are you taking any prescription medications, over-the-counter, natural remedies, vitamins or supplements?
Please list: ______________________________________
YES NO Are you allergic to any drugs, food, medications or latex?________________
YES NO Have you ever had a reaction to an anesthetic, drug or other substance ____________
YES NO Have you ever experienced excessive or prolonged bleeding?
YES NO Are you or could you be pregnant, nursing or taking oral contraceptives?

Have You Experienced Any Of The Following:

YES	NO	Chest Pain	YES	NO	Dizziness
YES	NO	Swollen ankles	YES	NO	Ringing in the ears
YES	NO	Shortness of breath	YES	NO	Headaches
YES	NO	Recent weight loss, fever, night sweats	YES	NO	Fainting spells
YES	NO	Persistent cough, coughing up blood	YES	NO	Blurred vision
YES	NO	Bleeding problems, bruising easily	YES	NO	Epilepsy or seizures
YES	NO	Difficulty swallowing	YES	NO	Excessive thirst
YES	NO	Frequent vomiting, nausea	YES	NO	Dry mouth
YES	NO	Difficulty urinating, blood in urine	YES	NO	Jaundice

Do You Have Or Have You Had:

YES	NO	Psychiatric care	YES	NO	Hospitalization
YES	NO	Radiation treatments	YES	NO	Blood transfusions
YES	NO	Chemotherapy	YES	NO	Surgeries
YES	NO	Prosthetic heart valve	YES	NO	Artificial joints

YES NO Do you have *or* have you had any other diseases or medical problems NOT listed above?

If so, please explain: ______________________________

Do You Have Or Have You Had:

YES	NO	Heart trouble, disease, attack, or defects	YES	NO	Positive HIV test or AIDS
YES	NO	Heart murmur or mitral valve prolapse	YES	NO	Tumors cancer
YES	NO	Stroke, hardening of arteries	YES	NO	Arthritis, rheumatism
YES	NO	Head and neck or mouth injuries	YES	NO	Eye diseases
YES	NO	High/Low blood pressure	YES	NO	Skin diseases
YES	NO	Asthma, TB, emphysema, other lung diseases	YES	NO	Anemia
YES	NO	Hepatitis, other liver disease	YES	NO	VD (syphilis or gonorrhea)
YES	NO	Stomach problems, ulcers	YES	NO	Cold sores, or oral lesions
YES	NO	Family history of diabetes, heart problems, tumors	YES	NO	Kidney, bladder disease
YES	NO	Diabetes	YES	NO	Thyroid, adrenal disease

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

Patient or Patient/ Guardian Date

Signed:

Dentist Date

Signed

Health History Reviewed on:

Date: ______________________ Signature: ______________________________

Cancellation Policy

Crestview Dental Group is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (408) 248-6777 by 3:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.** If prior notification is not given, you will be charged $100 for the missed appointment.

Please sign below to consent to these terms:

____

Client Signature (Client's Parent/Guardian if under 18) Date:

Crestview Dental Group
265 Crestview Drive, Santa Clara CA 95050
(408) 248- 6777

Patient Name: ______________________________ **Date:** ____________________

I have received and understand this dental practice's *Notice of Privacy Practices*, which is written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by the above dental office, as well as my individual rights and the dental practice's legal duties with respect to my protected health information.

This includes but is not limited to:

- **A statement that the dental practice is required by law to maintain privacy of protected health information**
- **A statement that this dental practice is required by abide by the terms of the notice currently in effect. Types of uses and disclosures that the dental practice is permitted to make for each of the following purposes; treatment, payment and healthcare operations**
- **A description of each of the other purposes for which the dental practice is permitted or required to use or disclose protected health information information without my written consent or authorization.**
- **My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:**
    - **The right to complain to the dental practice and to the Secretary of Human Health Services if I believe my privacy rights have been violated, and that no retaliatory action will be used against me in the event of such a complaint**
    - **The right to request restriction on certain uses and disclosures of my protected health information, and that the dental practice is not required to agree to a requested restriction.**
    - **The right to receive confidential communications of protected health information.**
    - **The right to inspect and copy my protected health information.**
    - **The right to amend protected health information.**
    - **The right to receive an accounting of disclosures of protected health information.**
    - **The right to obtain a paper copy of the Notice of Privacy Practices upon request.**

This dental practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this dental practice will provide me with a revised Notice of Privacy Practices upon request.

Patient or Patient/ Guardian **Date**

Signed:

Financial Policy

Crestview Dental Group is committed to providing you with excellent care. The following information describes our Financial Policy.
We accept cash, check, Visa, MasterCard and CareCredit. Financial arrangements must be established prior to treatment. If you are covered by dental insurance, we will be happy to process it for you. It is important that patients understand their policies clearly. Your insurance policy is between you, your employer and your insurance company. An estimate will be given to you on the understanding that it is but a GUIDELINE. **Therefore, we ask that you pay your estimated portion of your treatment on the day treatment is rendered.**
Upon receipt of the insurance payment, we will reconcile the account and send a statement with the remaining balance to you. **This balance is required to be paid in full. Any balance not paid within 30 days may be subject to a finance charge of 1.5% per month.** Occasionally, there are changes in treatment as it progresses, and should this occur, it would reflect a change in your anticipated estimate. If such changes in treatment do occur, you will be notified by Dr. Wallis immediately.
A fee of $50 will be charged for appointments that are cancelled without 24 hour notice.
For all returned checks there will be a fee of $25.00.
We are here to help. No question is too small for you to ask us, whether it is regarding your treatment, insurance, or bill. We ask that you call any time that you have a question.
Thank you,
Crestview Dental Group, DDS and Staff

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the named dental entity.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the named dental entity.

Patient or Patient/ Guardian **Date**

Signed: