Milpitas Smile Design

Patient Information

Date_____

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____Nick Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Home phone_____ Work phone_____

Cell phone_____ _____Email address_____

Are you: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated

Employer_____ Occupation_____

Business Address_____City_____State_____Zip_____

Spouse's name_____Employer_____

Spouse's Employer's Address_____Work phone#_____

If student, name of school/college_____ City_____State_____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____Phone#_____

Are you happy with your smile Y/N If no, why?_____

Responsible Party

Name of person responsible for this account?_____

Responsible Party's social security #_____Driver's License#_____

Relationship to patient_____Phone#_____

Address_____ City_____ State_____Zip_____

Name of employer_____ Work phone#_____

Dental Insurance

Primary Carrier

Insurance Company_____

Address_____

City_____State_____Zip_____

Tel_____Group#_____

Employer Name_____

Insured's Name_____

Insured's Date of Birth_____

Insured's SSN/ID#_____

Relationship to Patient_____

Secondary Carrier

Insurance Company_____

Address_____

City_____ State_____ Zip_____

Tel_____ Group #_____

Employer Name_____

Insured's Name_____

Insured's Date of Birth_____

Insured's SSN/ID#_____

Relationship to Patient_____

Dental History

Patient Name_____
Name, Address & Phone# of Former Dentist_____
Reason for today's visit_____
Date of last exam_____ Date of last dental x-rays_____
Check if any of the following conditions apply to you:

____ Bad Breath	____Grinding Teeth	____Sensitivity to hot
____Bleeding Gums	____Loose Teeth	____Sensitivity to cold
____Clicking or popping jaw	____Broken fillings	____Sensitivity to sweets
____Food collecting between teeth	____Sores/growths in mouth	____Sensitivity to biting

Medical History

Physician Name_____ Phone_____
Date of last visit_____ Reason_____
Please list all medications you are currently taking:_____
Have you ever had an allergic or adverse reaction to any medication or substance? Yes No
If yes, list medication _____
Describe reaction_____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
Do you have a history of the following? Circle "yes" or "no" to each item.

Heart (Surgery,Disease,Attack)	Y/N	Bleeding Disorders	Y/N	Stroke	Y/N
High Blood Pressure	Y/N	Thyroid Problems	Y/N	Ulcers	Y/N
High Cholesterol	Y/N	HIV Positive/AIDS	Y/N	STD	Y/N
Heart Valve Disorder	Y/N	Neurological Disorder	Y/N	Asthma	Y/N
Arthritis/Rheumatism	Y/N	Allergies or Hives	Y/N	Diabetes	Y/N
Cortisone Medication	Y/N	Radiation Therapy	Y/N	Emphysema	Y/N
Artificial Joints (Hip/Knee)	Y/N	Nervous/Anxious	Y/N	Tuberculosis	Y/N
Kidney Problems	Y/N	Hepatitis A or B or C	Y/N	Chemotherapy	Y/N
Psychiatric/Psychological Care	Y/N	Epilepsy/Seizures	Y/N	Sinus Trouble	Y/N
Latex Sensitivity	Y/N	Fainting/Dizzy Spells	Y/N	Tumors/Cancer	Y/N

Authorization

I certify that I have read and understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Parent/Guardian Signature Date

Practice Policies

We at Milpitas Smile Design are dedicated to serving you in caring for your oral health. We take great pride and care in providing the best in dental care to you and your family. Therefore, we will be more than happy to assist you with any financial matter related to you dental needs.

Payment Options:
We ask for payment in full at each dental visit. To accommodate you with this we accept the following methods of payment: Cash , Check, ATM/Check Card, Visa, MC, Amex, Discover and Care Credit, (with prior approval before your appointment).

Insurance/Finances :
We accept most insurance plans. Insurance plans are unique and adhere to specific covered and non-covered procedures depending upon your individual plan. We do our best to provide accurate treatment and insurance estimates with the information provided to us and from our initial contact with your insurance company. For your convenience we will prepare Treatment Estimates in advance of dental services. Treatment is recommended regardless of insurance deductibles, maximums and plan limitations. In order to keep our fees to you as low as possible we ask that deductibles and co-payments be paid at the time of service. For your convenience an estimate for dental care will be prepared prior to scheduled appointments to help you avoid unexpected balances. Please be advised that you are responsible for all balances not paid by your insurance company. Your assistance may be necessary to receive payment from your insurance in a timely manner.

Delinquent Accounts:
Account balances are due upon receipt of practice statements. A Service Fee of $25 will be charged for Returned Checks or Unapproved Card Payments. Unpaid balances where no agreement has been made with our Billing Department to extend payment may be transferred to a Collection Agency/Small Claims Court without further notice.

A**ppointments:**
Patient satisfaction and your time are very important to us. Every effort is made to stay on schedule so please arrive as scheduled. Advanced notice of 48 hours is requested to cancel appointments if necessary. Without sufficient notice, we do not have the opportunity to successfully fill your appointment therefore, that time remains open and it is too late to invite another patient for their care. A $50 fee may be charged for failed appointments when advanced notice has not been given.

I acknowledge that I have received and do understand MSD's Practice Policies

_____	_____	_____
Patient Name	Signature	Date

Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have received a copy of Milpitas Smile Design's (MSD) Notice of Privacy Practices (Notice) on this date indicated. If you have any questions regarding the information in MSD's Notice of Privacy Practices, please do not hesitate to contact a staff member.

Patient Name (printed): _____

Signature: _____

If Patient Representative, Name (Printed):_____

Relationship to Patient: _____ Date Notice Received: _____

THE DENTAL BOARD OF CALIFORNIA DENTAL MATERIAL FACT SHEET

The following document is the Dental Board of California's Dental Materials Fact sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact sheet, and its linkage to the DCA website does not constitute an endorsement to the content of this document.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE DENTAL MATERIAL FACT SHEET

Signature: _____ Date: _____

As required by chapter 8o1, statues of 1.992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be complete guide to dental materials science.

CONSENT FOR DENTAL TREAMENT

Consent for Dental Treatment I request and authorize Dr. Sandhu and her staff to provide me with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my dental health. At that time I request and authorize Dr. Sandhu and her staff to complete the accepted treatment for myself, (or my child).

Signature: _____Date: _____