Alegria Dental Group

New patient/medical history form

(Please print)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt. ____ City: _____

State: _____ Zip Code: _____ Home☎: (____) _____

Work☎: (____) _____ x_____ Cell : (____) _____

: _____ @ _____ marital status: S / M / D / W

Date of Birth: ___ / ___ / _____ Social Sec. No.: _____Occupation:_____

Delta Dental Insurance: Yes □ No □ If yes, Subscriber Name: _____ same □

Relation to Patient: Self □ Spouse □ Child □ Other □ Employer: _____

Group No.: _____ ID No.: _____

Second Dental Insurance Yes □ No □ or other Dental Insurance than Delta Dental Yes □ No □

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions concerning your health.

Are you in good health? Yes □ No □

Has there been any change in your general health within the past year? Yes □ No □

My last physical exam was on: _____

Are you now under the care of a physician? Yes □ No □

The name and address of my physician(s) is: _____

Are you taking any medications? Yes □ No □

If so, what: _____

Do you regularly take dietary supplements or herbal medicines? Yes □ No □

If yes, do you take any of the following?

□ Dietary or Energy supplements □ Echinacea □ Garlic □ Ginko □ Kava □ St. John's Wort

□ Valerian □ Ginger □ Ginseng □ Vitamin E >400 I.U □ Fish Oil > 3 grams/day

Do you regularly use natural or herbal oral health products? Yes □ No □

Have you recently substituted herbs for prescription or OTC drugs? Yes □ No □

Are you allergic to any medications? Yes □ No □

If so, what: _____

Have you had any serious illness or problem? Yes □ No □

If so, what was the illness or problem: _____

When was your last dental visit? _____

Are you having any dental discomfort at this time Yes □ No □

Have you had any serious trouble associated with previous dental treatment? Yes □ No □

If so, explain: _____

Does dental treatment make you nervous? Yes □ No □

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? If so, when: _____ Yes □ No □

How often do you brush? _____

How did you hear about us? ☺

Delta Dental Website □ Yellow Pages □ Search Engine □ Other □ _____

Family member □ Friend □ Coworker □ Referring Doctor □ if applicable, please let us know the name of the person that referred you to us: _____

(TURN OVER)

Alegria Dental Group

NEW PATIENT/MEDICAL HISTORY FORM

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

Abnormal bleeding	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
Alcohol Abuse	Yes ☐ No ☐	If yes, do you need to premedicate?	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
If yes: _____		Hepatitis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Angina Pectoris	Yes ☐ No ☐	HIV+	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	AIDS	Yes ☐ No ☐
Artificial Bones	Yes ☐ No ☐	Irritable Bowel Syndrome	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Kidney/Liver Problems	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐
Cancer- Chemotherapy	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Colitis	Yes ☐ No ☐	Pneumocystitis	Yes ☐ No ☐
Congenital Heart Defect	Yes ☐ No ☐	Psychiatric Problems	Yes ☐ No ☐
Cosmetic Surgery	Yes ☐ No ☐	Radiation Therapy	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Difficulty Breathing	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Drug Abuse	Yes ☐ No ☐	Shingles	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Sinus Problems	Yes ☐ No ☐
Fainting Spells	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Fever Blisters	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Frequent Headaches	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Hay Fever	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Yellow Jaundice	Yes ☐ No ☐
Heart Surgery	Yes ☐ No ☐		

Do you smoke or use tobacco? Yes ☐ No ☐

If there was one thing about your smile you could change what would it be?

_____

For women:

Are you taking birth control pills? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

If yes, number of weeks: ____

Are you nursing? Yes ☐ No ☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient

Date

Alegria Dental Group
Financial Agreement

- I understand and accept that I am responsible for all payments whether the treatment is covered by insurance or not.
- I understand that my insurance contract is between the insurance company, my employer and me. Any efforts to collect payment from the insurance company will be handled as a courtesy by the dental office.
- I understand that insurance coverage costs quoted to me are **ESTIMATES** of what my insurance company may pay.
- I understand that it is my responsibility to inform the office of any changes in my dental coverage.
- I understand that it is my responsibility to inform the office if I have had treatment at another facility prior to coming to this office.
- I am aware that delinquent accounts may be turned over to collections if payment arrangements are not made and I am responsible for any costs incurred.
- I understand my insurance coverage that has been explained to me.
- I understand that all co-payments/payments are due on **the date of service**.
- Payments are to be made only in the form of cash, checks, money order, VISA or MasterCard
- I acknowledge that appointments are confirmed in advance as a courtesy, and that failure to show for my appointment without giving adequate notice will result in a $75 charge to my account.

I have read, understand and accept the 10 financial agreement terms as listed above.

Date **Signature of Insured/Guardian**

CHECK RETURN FEE

I understand that if I write a check to Alegria Dental Group for payment of treatment or services rendered and the **check is returned for insufficient funds**, I am still responsible for the payment due (which must be made in the form of cash, money order or credit card) as well as an **additional $25.00 check return fee.**

Date **Signature of Insured/Guardian**