PATIENT REGISTRATION

PATIENT INFORMATION

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

Date of Birth: _____/_____/_____ **SSN:** _____-_____-_____ **Driver Lic/ID:** _____ **Type:** _____ **State:** ____

Sex: ◯ **Male** ◯ **Female** **Marital Status:** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Separated** ◯ **Widowed**

Home Address:_____**City:**_____ **State:**____ **Zip:**_____

Home Phone: (____)_____-_____ **Work :** (____)_____-_____ **Ext:**_____ **Cell:** (____)_____-_____

Email: _____ **Preferred Contact:** ◯**Email** ◯**Home** ◯**Work** ◯**Cell**

Emergency Contact Name: _____ **Phone:** (____)_____-_____ **Relationship:** _____

RESPONSIBLE PARTY (if different from above)

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

Date of Birth: _____/_____/_____ **SSN:** _____-_____-_____ **Driver Lic/ID:** _____ **Type:** _____ **State:** ____

Sex: ◯ **Male** ◯ **Female** **Marital Status:** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Separated** ◯ **Widowed**

Home Address:_____**City:**_____ **State:**____ **Zip:**_____

Home Phone: (____)_____-_____ **Work :** (____)_____-_____ **Ext:**_____ **Cell:** (____)_____-_____

Email: _____ **Preferred Contact:** ◯**Email** ◯**Home** ◯**Work** ◯**Cell**

Emergency Contact Name: _____ **Phone:** (____)_____-_____ **Relationship:** _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to insured:_____

Insured Social Security #: _____-_____-_____

Insured Date of Birth: _____/_____/_____

Employer:_____

Phone: (____)_____-_____

Address: _____

_____

Insurance Company Name: _____

Phone: (____)_____-_____

Policy #/ID: _____

Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____

Relationship to insured:_____

Insured Social Security #: _____-_____-_____

Insured Date of Birth: _____/_____/_____

Employer:_____

Phone: (____)_____-_____

Address: _____

_____

Insurance Company Name: _____

Phone: (____)_____-_____

Policy #/ID: _____

Group #: _____

DENTAL HISTORY

Patient Name:_____ **Date:**_____

Whom may we thank for inviting you to our office? _____

When was you last visit to a dentist?_____

Why did you leave your last dentist?_____

What is the reason for today's visit?_____

_____

Do you like your smile? ◯ **Yes** ◯ **No**

What would you like to change about your smile?_____

_____

Is there anything that you would like to change or make better about your teeth or gums? _____

_____

Have you ever had a bad experience at a dental office? ◯ **Yes** ◯ **No**

Are you nervous in the dental chair? ◯ **Yes** ◯ **No**

What can we do to make you experience more enjoyable? _____

_____

Do you have any goals for dental treatment?_____

_____

Do your gums bleed when you floss?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Are you sensitive to hot, cold, sweets, or pressure?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Does food get caught in your teeth?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Is your mouth dry?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Have you had Orthodontic treatment? _____ ◯ **Yes** ◯ **No** ◯ **DK**

Have you had Periodontal treatment? _____ ◯ **Yes** ◯ **No** ◯ **DK**

Do you have neck pain or earaches?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Does your jaw click, pop, or hurt?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Do you grind your teeth?_____ ◯ **Yes** ◯ **No** ◯ **DK**

Do you wear dentures or partials?_____ ◯ **Yes** ◯ **No** ◯ **DK**

MONA MOY, DDS
2220 Mountain Blvd #205 / Oakland CA. 94611 / 510.482.2799 / montclairdentist@gmail.com

Time 9:08 AM | Mona Moy DDS | Date 6/3/2015

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

TREATMENT CONSENT

I hereby authorize the doctors, assisted by dental auxiliaries of their choice, to perform the following dental treatment, if needed or recommended:

- Examination of the teeth, mouth and neck
- Radiographs (x-rays) of the teeth and jaws
- Cleaning of the teeth and application of fluoride
- Application of plastic dental sealants to the grooves of molars
- Use of local anesthesia to numb the teeth and surrounding tissues
- Treatment of injured or diseased teeth with tooth colored fillings (composites) and crowns(stainless steel or composite)
- Pulpotomy or root canal (treatment of diseased nerve)
- Extraction of diseased, nonrestorable teeth, or extractions requested by an orthodontist
- Replacement of extracted or missing teeth with a space maintainer or dental prosthesis to help preserve the position and health of the surrounding teeth and tissues.
- Orthodontic or ALF treatment
- Use of nitrous oxide to reduce anxiety
- Other:_____

The doctors have explained the nature and purpose of the treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, risks, consequences and probable effectiveness of each, as well as prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.

I further authorize the doctors to perform other dental service(s) that in their judgment are advisable for the care of myself/ my child /legal ward, with the exception of (if none, so state):

_____

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the application of topical fluoride if it is swallowed and children biting and injuring their tongue or lip following the administration of local anesthesia. For children with heart disease, the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before the treatment to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment and may require hospitalization.

Additional risks include: _____

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my or my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

Patient's name: _____ or Parent/Guardian's Name : _____

_____ _____

Signature of Responsible Party Date

_____

Relationship to Patient

MONA MOY, DDS
2220 Mountain Blvd #205 / Oakland CA. 94611 / 510.482.2799 / montclairdentist@gmail.com

OFFICE POLICIES

We appreciate you choosing our practice for your dental needs. We are committed to providing you with the highest quality dental care using the best materials and technology available in the market today. Our office offers a relaxing environment, with a friendly and attentive staff. All of our treatment is designed to be comfortable, long-lasting, and to exceed your expectations. We would like to develop the best possible professional relationship with you.

Please initial below to show informed consent of our office policies.

FINANCIAL AGREEMENT

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial treatment should not be an obstacle to obtaining this important, life-changing care. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

_____ **I understand that I am responsible for payments in full at time of service.** I understand that I am able to pay with check, cash, credit card, or Care Credit. Finance charges will accrue on any unpaid balances past 30 days. Returned checks will incur a $25 fee. Any and all financial arrangements must be made prior to treatment.

_____ **I understand that Dr. Moy is not a participating member of any dental plan.** If I have a dental plan, Dr. Moy's office would be happy to file my dental claims on my behalf. Dr. Moy will make every effort to see that I am reimbursed at the maximum level for my plan. The dental plan will reimburse me directly. As Dr. Moy is not a member of any dental plan and I may be reimbursed at a lower level.

APPOINTMENTS

Our biggest strength lies in how you are treated. We try to allow extra time so that you are never rushed. We strive to honor everyone's time commitments and request that you extend the same courtesy to us. Your appointment is reserved especially for you.

_____ **I understand that if I must reschedule or cancel an appointment, I am required to give 48 hours notice to allow Dr. Moy's office to schedule someone else for that reserved time.** I understand that missing dental appointments may jeopardize my oral health. I am aware that I may be assessed a fee for missed /cancelled appointments with less than a 48 hour notice.

Please call us during working hours. Leaving a message on our answering service after hours will roll over to the next working day.

I have read and understand the financial agreement and terms stated within.

_____ _____

Signature of Responsible Party **Date**

_____

Printed Name

_____ _____

Patients Name if Different **Relationship to Patient**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Mona May to release/procure any x-rays or dental records to/from another practitioner in the course of my care. Medical information will not be shared without my consent. A copy of this authorization is accepted with the same authority as the original.

_____ _____

Signature **Date**

AUTHORIZATION TO RELEASE PHOTOS

I hereby authorize Dr. Mona May to use photos of my teeth for demonstration of oral care.

_____ _____

Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Signature **Date**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Initials _____ **Date** _____ **Reason** _____

_____