ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____

I prefer to be called: _____ _____

Birth date: _____/_____/_____ Age: _____

SS#: _____

Home address: _____

City: _____ St. _____ Zip _____

Home Phone#: _____

Cell/Other#: _____

Work Phone#:(_____) _____ Ext: _____

Driver's License#: _____

Marital Status:

❑ Single ❑ Married ❑ Partnered

❑ Divorce/Separated ❑ Widowed

Employer: _____

Occupation: _____

When and where are best times to reach you? _____

_____

Whom May we thank for referring you? _____

Others Family members seen by us? _____

Optional Info to help the doctor get to know you:

Your Special Interest/Hobbies: _____

How long have you lived in area? _____

SPOUSE INFORMATION

His/Her Name: _____

Employer: _____

Work Phone#:(_____) _____ Ext: _____

SS#: _____

Birth date: _____/_____/_____ Age: _____

Driver's License#: _____

PRIMARY INSURANCE

Dental Coverage ❑ Yes ❑ No

Insurance Co Name: _____

Insurance Co. Address: _____

City: _____ St. _____ Zip _____

Insurance Co. Phone#:(_____) _____

Group #(Plan, Local, or Policy): _____

Insured's Name: _____ Relation _____

Insured's Birth date ____/___/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

City: _____ St. _____ Zip _____

SECONDARY INSURANCE

Dental Coverage ❑ Yes ❑ No

Insurance Co Name: _____

Insurance Co. Address: _____

City: _____ St. _____ Zip _____

Insurance Co. Phone#:(_____) _____

Group #(Plan, Local, or Policy): _____

Insured's Name: _____ Relation _____

Insured's Birth date ____/___/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

City: _____ St. _____ Zip _____

Authorization and Release:

I understand that I am Responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature of patient:

_____

Date:

_____

MEDICAL HISTORY

Do You Have a personal Physician? ☐ Yes ☐ No
Physician's Name:_____
Phone#:(_____)_____
Do you smoke or use tobacco in any form? ☐ Yes ☐ No
Have you had any metals rod, pins, or implants? ☐ Yes ☐ No
Are you taking any prescriptions/over the counter drugs? ☐ Yes ☐ No
Please List each One: _____
_____
_____
_____

Have you ever taken Fosamax, or any other Bisphosphonate? ☐ Yes ☐ No
Have you ever taken Phen-fen? ☐ Yes ☐ No
Have you ever had a blood transfusion? ☐ Yes ☐ No

For Women Only

Are you using a prescribed method of birth control? ☐ Yes ☐ No
Are You Pregnant? Week#____ ☐ Yes ☐ No
Are You Nursing? ☐ Yes ☐ No
Are you taking any birth control? ☐ Yes ☐ No

Have you ever had any of the followings diseases or medical problems?

Abnormal Bleeding	☐ Yes ☐ No	Herpes /Fever Blisters	☐ Yes ☐ No
AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Alcohol/Drug abuse	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hospitalized for any reason	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Artificial Bones/Joints/Valves	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	Mitral Valve Prolapsed	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Difficulty Breathing	☐ Yes ☐ No	Rheumatic/Scarlet fever	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Fainting Spells	☐ Yes ☐ No	Sickle Cells Disease/Traits	☐ Yes ☐ No
Frequent Headache	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Heart Attack/Surgery	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No		

Please List any serious medical condition(s) that you ever had:

_____
_____
_____

Medications:

List Medications (Prescribed/etc) you are currently taking:

_____
_____
_____

Are you allergic to any of the following:

Aspirin	☐ Yes ☐ No	Jewelry Metals	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Dental Anesthetics	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	Other	☐ Yes ☐ No

Please list any drugs /materials that you are allergic to:

_____
_____
_____

DENTAL HISTORY

Reason For Today's Visit:_____
_____
Former Dentist:_____
Address:_____
Date Of Last Dental Visit:_____
Date Of Last Dental X-rays:_____
Your Current dental health is ☐ Good ☐ Fair ☐ Poor
Are You currently In Pain? ☐ Yes ☐ No
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
Have you ever had Periodontal Disease? ☐ Yes ☐ No
Do You now or have ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ? ☐ Yes ☐ No
Are your teeth sensitive to sweets,heat,cold or anything else? ☐ Yes ☐ No
Are your teeth sensitive when biting? ☐ Yes ☐ No
Do you have sores of growth in your mouth? ☐ Yes ☐ No
Do you have any loose teeth? ☐ Yes ☐ No
Do you still have wisdom teeth? ☐ Yes ☐ No
Would You Like Fresher Breath? ☐ Yes ☐ No
Whiter Teeth? ☐ Yes ☐ No
Are you happy with the way your smile looks? ☐ Yes ☐ No

If not,what would you change?_____
_____
_____
_____

Authorization and Release:

I have read the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all the charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor:

_____

Date:

_____

OFFICE USE ONLY

I verbally reviewed the Medical / Dental Infomation with the patient named herein.

Initials:_____Date:_____

Doctor's Commets:_____
_____
_____
_____
_____
_____

Whom may we thank for referring you to Brentwood Dental Center? We want to thank them because we are always accepting new patients and we welcome all referrals.

Name: _____

Our office is HIPAA Compliant

THIS IS MY AUTHORIZATION TO DR. ANU AHEER TO PERFORM ALL NECESSARY DIAGNOSTIC, PREVENTIVE, RESTORATIVE, SURGICAL, ORTHODONTIC AND ASSOCIATED DENTAL TREATMENT. I WILL BE ADVISED OF ALL METHODS, MEDICATIONS AND AGENTS AS MAY BE INDICATED AND CONSENT THEREBY, MY CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED IN WRITING.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED, BRENTWOOD DENTAL CENTER, FOR DENTAL BENEFITS. OTHERWISE MADE PAYABLE TO ME FOR DENTAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

FINANCIAL POLICY / CANCELATION POLICY

For your convenience we accept Visa, MasterCard and Discover. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered unless other arrangements have been made in advance.
We work with Care Credit and have information on the Care Credit program available
To avoid a $50 cancelation fee, Please cancel your appointment 24 hours prior to scheduled service.
If you have questions regarding your account, please contact us at 925-634-9594

Note: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian **Date**

_____

Signature of Dentist **Date**

_____