SPRING VALLEY DENTAL GROUP

Our goal is to help you have healthy teeth and provide the best dental care possible. Please help us by providing the following information:

ABOUT YOU

Name: ____

Address: ____

City/State/Zip: ____

Nickname/Prefer: ____

Home #: ______________________ Work #: __________________________

Mobile #: _______________________ May we contact via Mobile? ☐ Y ☐ N

E-mail Address: ____

Birth date: _______ / ________ / ________ Age: _______ Gender: ☐ M ☐ F

Employer: ____

Occupation: ____

Social Security #: ____

Marital Status: _________________ Spouse's Name: ____________________

In case of emergency please contact *(name, phone & relationship)*:

YOUR DENTAL HISTORY

Why have you come to see us today? _________________________________

____

Is there anything you would like to change about the appearance of your teeth or smile? ____

____

Date of last Dental Exam: _________ / _________ / _________

Has your dental care been:

☐ Regular (every 6 mo.) ☐ Sporadic ☐ Emergencies Only

Are you apprehensive about dental treatment? ☐ Y ☐ N

Do your gums bleed when you brush or floss? ☐ Y ☐ N

Are you interested in whitening and/or straightening your teeth? ☐ Y ☐ N

Whom may we thank for referring you to our office?

MEDICAL HISTORY

Heart Failure	Y	N	Stroke	Y	N	Hay Fever	Y	N	Arthritis	Y	N
Heart Attack	Y	N	Aneurysm	Y	N	Sinus Problems	Y	N	Artificial Joints	Y	N
Angina/Chest Pain	Y	N	Epilepsy/Seizures	Y	N	Allergies	Y	N	Osteoporosis/Meds	Y	N
High Blood Pressure	Y	N	Frequent Headaches	Y	N	Asthma	Y	N	Cancer	Y	N
Heart Murmur	Y	N	Fainting/Dizziness	Y	N	Emphysema	Y	N	Chemotherapy	Y	N
Mitral Valve Prolapse	Y	N	Glaucoma	Y	N	Tuberculosis (TB)	Y	N	Radiation	Y	N
Heart Defect	Y	N	Psychiatric Treatment	Y	N	Difficulty Breathing	Y	N			
Artificial Heart Valve	Y	N	Drug/Alcohol Abuse	Y	N	Sleep Apnea	Y	N	Herpes	Y	N
Rheumatic Fever	Y	N	Auto Immune Disorder	Y	N	CPAP	Y	N	HIV/AIDS	Y	N
Irregular Heart Beat	Y	N	Blood Transfusion	Y	N				Venereal Disease	Y	N
Pacemaker	Y	N	Hemophilia	Y	N	Liver Disease	Y	N	Recreational Drugs	Y	N
Heart Surgery	Y	N	Leukemia	Y	N	Hepatitis	Y	N	Tobacco Use	Y	N
Bacterial Endocarditis	Y	N	Anemia	Y	N	Kidney Disease	Y	N	**WOMEN**:		
Other Heart Problems	Y	N	Sickle Cell Disease	Y	N	Organ Transplant	Y	N	Are you pregnant?	Y	N
If Y, list: ____________________			Abnormal Bleeding	Y	N	Diabetes	Y	N	If Y, when due? ______________		
__________________________			Blood Thinners	Y	N	Thyroid Problems	Y	N	Are you nursing?	Y	N
__________________________			Acid Reflux	Y	N	Ulcers	Y	N	Birth control pills?	Y	N

Physician's Name, Address & Phone: ____

Date of Last Physical Exam: ____

ALLERGIES: Are you allergic to Penicillin, Aspirin, Codeine, Dental Anesthetics, Latex, or any other medication or substance? ☐ Yes ☐ No

If yes, please list: ____

MEDICATIONS: Are you taking any medications, herbs or supplements? ☐ Yes ☐ No

If yes, please list: ____

Have you ever been told to take a pre-medication prior to dental appointments? ☐ Yes ☐ No

Do you have any medical concern or condition not listed? ☐ Y ☐ N If Yes, Explain: ________________________________

To the best of my knowledge, all of the preceding is correct. If I ever have a change in my health, medication, or medical condition, I will inform the dentist at my next appointment. I authorize release of any information to my insurance company and/or other health care providers involved in my treatment.

Patient Signature: ____ **Date**: ________ / ________ / ________

Notes: ____

Doctor's Signature: ____ **Date**: ________ / ________ / ________

INSURANCE AND BILLING INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT

☐ Self (skip this section) ☐ Other

Relationship to the Patient: ____________________ Work Phone #: ____________________

Name: ____________________ Home Phone #: ____________________

Address: ____________________ Cell Phone #: ____________________

____

Employer: ____________________ Birth date: ______ / ______ / ______ Age: ________

Occupation: ____________________ Gender: ☐ Male ☐ Female

Social Security #: ____________________ Marital Status: ________ (*Spouse's Name*____________________)

IF YOU HAVE DENTAL INSURANCE

If you have dental insurance, we will be happy to assist you in obtaining benefits, and will *estimate* your benefits based upon your policy information. It is important for you to understand insurance plans vary greatly from plan to plan and/or from employer to employer, so we cannot be certain what benefits your insurance company will pay. Any questions over coverage is ultimately the responsibility of your insurance company.

PRIMARY

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: ____________________

Address: ____________________

____

Birth date: ______ / ______ / ______

Social Security #: ____________________

Insured's Employer: ____________________

Group #: ____________________

Subscriber/Member ID#: ____________________

Ins. Co. Address: ____________________

Ins. Co. Telephone: ____________________

SECONDARY

Patient's Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: ____________________

Address: ____________________

____

Birth date: ______ / ______ / ______

Social Security #: ____________________

Insured's Employer: ____________________

Group #: ____________________

Subscriber/Member ID#: ____________________

Ins. Co. Address: ____________________

Ins. Co. Telephone: ____________________

ACCOUNT AGREEMENT

As the person responsible for this account, I understand that I am responsible for payment of services rendered. Payment is due at the time of service unless other written arrangements have been made. I hereby authorize payment of insurance benefits directly to Spring Valley Dental Group, and understand that any disparity in coverage is a matter between my insurance company and me. I understand that any balance not paid within 90 days from the date services are rendered may be subject to finance charges. I understand that I will be assessed a fee of $25 for any returned check payments. In the event of non-payment, you will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 50% of the total balance and will be added to the account if it is turned over to an outside agency. For your convenience, we accept cash, personal checks, MasterCard, VISA, Discover, American Express and Care Credit.

Patient Signature: ______________________________ Date: ______ / ______ / ______