Welcome **Michael O'Brien D.D.S.**

Patient Information
Whom may we thank for referring you?
____

Date______________________________________

Patient Name______________________________

Address___________________________________

City______________________________________

State _______________ **Zip** ______________

SSN#______________________________________

Sex: **M**____ **F**____ **Age**_____ **Date of Birth**_________

Minor_____**Single**_____**Married**_____**Partnered**____
Separated______**Divorced**______ **Widowed**_______

Who is responsible for this account?
____

Relationship to Patient_______________________

Occupation________________________________

Employer__________________________________

Employer's Address___________________________

City/State/Zip_______________________________

Employer's Phone_____________________________

Spouse's Name_______________________________

Date of Birth__________**SSN#**__________________

Spouse's Employer____________________________

Dental Insurance
Insurance ____________________ **Ph#**_______________

Subscriber Name_________________________________

ID #_____________________ **Group#**_________________

Date of Birth_________ **Relationship to pt.**

Secondary Ins._________________**Ph#**______________

Subscriber Name__________________ **DOB**___________

ID#________________________ **Group#**______________

Relationship to patient_____________________________

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with_____________________________ and assign directly to La Mesa Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of patient, parent, or guardian (responsible party):

______________ ______________________________
Date Relationship to patient

Telephone numbers
Cell______________________ **Home**______________________ **Work**______________________**Ext**___________

Spouse's Work_______________________________ **E-mail**_____________________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household, if possible)
Name______________________**Relationship**_______________ **Cell/Home#** _______________ **Work#** __________
Please understand that any expense not covered by your insurance is your responsibility. Your estimated share of cost is expected on the date services are rendered. Please ask us about different payment options, if needed.

Name______________ **Physicians name**_______________ **Dr.'s Phone** ______________**Date of last physical** ________

Have you ever taken any of the group of drugs collectively referred to as "**fen-phen**?'These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). **Yes**☐ **No**☐

Have you taken any of the **bisphosphonate drugs**? Aredia☐ Actonel ☐Boniva ☐Fosamax ☐ Zometa☐ Other☐ **None**☐

Please indicate if you have experienced any of the following, check yes or no:

Heart Murmur	yes☐ no☐	Kidney Disease	yes☐ no☐	Tuberculosis	yes☐ no☐
Heart Problems or Surgery	yes☐ no☐	Prolonged Bleeding	yes☐ no☐	Fainting/Dizziness	yes☐ no☐
Congenital Heart Lesions	yes☐ no☐	Liver Disease	yes☐ no☐	Asthma/Sinus Trouble	yes☐ no☐
High Blood Pressure	yes☐ no☐	Psychiatric Care	yes☐ no☐	Headaches	yes☐ no☐
Low Blood Pressure	yes☐ no☐	Diabetes: Type_______	yes☐ no☐	Breathing Problems	yes☐ no☐
Mitral Valve Prolapse	yes☐ no☐	AIDS/HIV	yes☐ no☐	Back Problems	yes☐ no☐
Artificial Heart Valves	yes☐ no☐	Thyroid Problems	yes☐ no☐	Cancer	yes☐ no☐
Pacemaker	yes☐ no☐	Herpes	yes☐ no☐	Difficulty Reclining	yes☐ no☐
Rheumatic Fever	yes☐ no☐	Smoke/Tobacco	yes☐ no☐	Radiation Treatment	yes☐ no☐
Arthritis, Rheumatism	yes☐ no☐	Circulatory Problems	yes☐ no☐	Hospitalized Recently	yes☐ no☐
Drug Addiction	yes☐ no☐	Emphysema	yes☐ no☐	Chemotherapy	yes☐ no☐
Stroke	yes☐ no☐	Anemia	yes☐ no☐	Sleep Apnea	yes☐ no☐
Shortness of Breath	yes☐ no☐	Cough, persistent/bloody	yes☐ no☐	Cholesterol	yes☐ no☐
Artificial Joints	yes☐ no☐	Epilepsy	yes☐ no☐	Hepatitis: Type______	yes☐ no☐

Condition not listed? yes☐ no☐ ____

Women: Are you pregnant? yes☐ no☐ Due Date_________ Nursing? yes☐ no☐ Taking birth control pills? yes☐ no☐

Medications List medications you are taking and why: **None**☐

____

____

____

Pharmacy__________________Phone__________________

Allergies **None**☐

Aspirin☐ Codeine☐ Penicillin☐

Latex☐ Local Anesthetic☐

Sulfa☐ Iodine☐

Metal☐ Other☐__________________________

Dental History: **Please check "Yes" or "No" to indicate if you have had any of the following:**

Teeth whitening	yes☐ no☐	Braces retainers	yes☐ no☐	Reason for today's visit________
Mouth sores or growths	yes☐ no☐	Broken fillings or tooth	yes☐ no☐	________________________
Lip/cheek biting	yes☐ no☐	Food collection between teeth	yes☐ no☐	Former Dentist______________
Grinding teeth	yes☐ no☐	Sensitivity cold, heat, sweets	yes☐ no☐	Last visit__________________
Chew on one side of mouth	yes☐ no☐	Bad breath	yes☐ no☐	Last x rays_________________
Pain around ear(s)	yes☐ no☐	Gums swollen, tender, bleeding	yes☐ no☐	How often do you brush?______
Clicking/popping jaw	yes☐ no☐	Gum surgery or loose teeth	yes☐ no☐	How often do you floss?______
Jaw pain/tiredness	yes☐ no☐	Sensitivity when biting	yes☐ no☐	City/State__________________
Do you like your smile?	yes☐ no☐	If not what would you like to change?____________________________________		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient signature_______________________ Date__________ Staff Signature_______________________Date________

Date	Any Changes? If yes, please list them		Signature
________	yes☐ no☐	____________________________________	________________________
________	yes☐ no☐	____________________________________	________________________

Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless a prior payment arrangement has been made.

Payment options:

1. Cash
2. Check
3. Major credit cards (American Express, Master Card, Visa, Discover)
4. Care Credit
5. Credit card authorization for recurring charges:
    a. Treatment exceeds 400$
    b. Plan may not exceed 4 months

Patient with insurance: The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and /or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization).

Parents accompanying their children are financially responsible for payment.
There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Records can be viewed at anytime. There is a nominal charge for release or copies of records.

Broken Appointment Policy:
Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$50 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 48 BUSINESS HOURS IN ADVANCE.**
I, ____________________________________, agree to these financial terms.

Signature ______________________________, Date __________.