CALI BAY DENTAL CARE

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Welcome to Cali Bay Dental Care! Please fill out this CONFIDENTIAL registration form.

First Name_____Middle_____Last _____

Preferred name_____Birthdate (MM/DD/YYY) _____

Address_____City_____Zipcode _____State_____

Home phone_____Work phone_____Cell phone _____

E-mail address_____Social Security Number _____

Sex: ☐ Male ☐ Female Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer_____Occupation _____

Emergency Contact_____Relationship_____Phone _____

How did you hear about our office? ☐ Insurance Company ☐ Walk In ☐ Website ☐ Facebook

Friend / Family Name_____Other _____

Person Financially Responsible for this Account _____

Relationship_____Home Phone_____Cell Phone _____

Primary Insurance

Subscriber Name _____
Subscriber SSN _____
Date of Birth _____

Relationship to Subscriber :
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Employer Name _____
Insurance Carrier _____
Insurance Policy / ID # _____
Group # _____

Secondary Insurance

Subscriber Name _____
Subscriber SSN _____
Date of Birth _____

Relationship to Subscriber :
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Employer Name _____
Insurance Carrier _____
Insurance Policy / ID# _____
Group # _____

Please fill out this CONFIDENTIAL medical and dental history information.

Health Information

Are you under a physician's care? Yes / No Physician's Name _____
_____ Physician's office address_____
_____Office phone ____ Have you ever been hospitalized or had a major operation? □ Yes □ No
If Yes, please explain: _____
_____
Reason for today's visit? _____
Date of last dental visit? _____
If wearing dentures or partials, age of denture or partial? _____
How frequently do you brush your teeth?_____How frequently do you floss your teeth? _____

Do your gums bleed? Yes / No
Have your gums receded? Yes / No
Do you have persistent sore throat or ear pain? Yes / No
Do you or have you been told you snore? Yes / No
Have you been diagnosed with sleep apnea? Yes/ No
Do you have chronic hoarseness? Yes / No
Are your gums sore or swollen? Yes / No
Are your teeth loose? Yes / No
Do you have a lump or thickening in the cheek? Yes / No
Do you regularly have excessive daytime sleepiness? Yes / No
Do you have a family history of diabetes? Yes / No
Do you have high cholesterol? Yes / No
Do you have unexplained numbness or pain in the face/neck/mouth? Yes / No
Do you have a sore or lesion on the lips/mouth that has persisted for 2 weeks or more? Yes / No
Do you have difficulty chewing, swallowing, or moving the jaw or tongue? Yes / No
Do you bleed or bruise easily? Yes/ No
Is there history of heart disease in your immediate family? Yes / No

Do you have history of: (Please circle Y or N)

Y N Epilepsy / Seizures
Y N Psychiatric Disorder
Y N Joint Replacement
Y N Chemical Dependency
Y N Recurrent Bronchitis
Y N Stomach/Intestinal Disease
Y N High Blood Pressure
Y N Pneumonia
Y N Skin Disorder
Y N Heart Surgery
Y N Tuberculosis
Y N Diabetes
Y N Heart Attack
Y N Hepatitis (type A, B, C)
Y N Anemia / Hemophilia
Y N Stroke
Y N Kidney Failure
Y N Venereal Disease
Y N Pacemaker
Y N Chest Pains/Angina
Y N HIV / AIDS
Y N Asthma
Y N Heart Disease
Y N Kidney Stones
Y N Cancer
Y N Thyroid Disease
Y N Osteoporosis
Y N Bisphosphonate usage
Y N Mitral Valve Prolapse
Y N Other _____
_____

Are allergic to any of the following, please circle:
Penicillin Aspirin Codeine Latex None Other: _____

Do you smoke? Yes / No Packs per day? _____
Do you drink alcoholic beverages? Yes / No Drinks per week? _____
Are you pregnant? Yes/ No If so, how many months? _____

List all medications you are currently taking: _____

_____

Dr Signature _____

Financial Policies and Acknowledgements

We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment. In order to be impartial to everyone, **WE REQUIRE PAYMENT AT THE TIME OF THE TREATMENT**. We ask that you read and sign this statement prior to any treatment. **YOUR CO-PAY AND DEDUCTIBLE ARE DUE IN FULL AT THE TIME OF THE TREATMENT**. We accept cash, checks, Visa, MasterCard, Discover Card, and American Express. For extensive treatment plans, we offer extended payment plans with CareCredit at no interest with prior credit approval.

Please initial the following:

_____ **ACKNOWLEDGEMENT**
I hereby certify that the medical and dental history provided is correct to the best knowledge and give my consent for Dr. Zander Lin, associates, and the staff at Cali Bay Dental Care to treat my dental needs based on this information.

_____ **MISSED APPOINTMENTS**
In order to be fair to all our patients, we ask that you notify our office at least 48 hours in advance if you cannot keep your scheduled appointment. Our policy for the first missed appointment is a charge of $25 and $50 for any additional missed appointment without a 48 hour notice.

_____ **WARRANTY**
Cali Bay Dental Care warranties all dental treatment. Composite fillings needing to be replaced have a warranty of one year from original date of service. Crowns, veneers, bridges, dentures, and partials needing to be repaired or replaced also have a one year warranty from the original date of service. At no time will a refund be given for dental treatment.

_____ **USE OF ILLICIT / ILLEGAL DRUGS**
The use of illicit or illegal drugs can adversely affect treatment, including anesthesia and sedation, possibly resulting in death. Please notify the doctor if you have used any drugs within the last 24 hours.

_____ **DIGITAL RADIOGRAPHS / X-RAYS / PHOTOGRAPHS**
I authorize Dr. Lin and his team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company for processing my dental claim (if applicable and according to HIPPA regulations). A fee of $25 will be charged if a patient requests a copy of his or her own records for personal use.

_____ **PRIVACY**
Dr. Zander Lin, associates, and staff agree to and take great care in being able to extend a higher level of privacy than is required by HIPAA, state confidentiality law, and common law. WE WILL NEVER UNDER ANY CIRCUMSTANCES SELL PATIENT LISTS OR PROTECTED HEALTH INFORMATION TO ANY

THIRD PARTY FOR THE PURPOSE OF MARKETING TO OUR PATIENTS. We do not believe in this manner of marketing and we do not think it is in our patients' best interest.

(Optional) AUTHORIZATION FOR DENTAL CARE ON A MINOR

I authorize dental treatment to be rendered on my child/minor, _____, without my physical presence in the dental office. I have been advised that it is ideal to have a parent/legal guardian present in the office during treatment in case of any complications or medical situations that may arise. With knowledge of this, I authorize the Cali Bay Dental Care Team to take any emergency care/action or precautions deemed necessary. I still retain the authority to approve or decline treatment to be rendered and will make that designation clear before the appointment either in person or by phone consent.

Patient Name _____

Signature of Parent/Guardian _____

REGARDING INSURANCE

I, the undersigned patient, understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. As a courtesy, our office will file claims to your insurance company. However, your insurance is a contract between you and your insurance company. Insurance companies frequently reimburse at a lower rate than we estimate. When this occurs you may be required to pay an additional "after insurance" balance. I authorize Cali Bay Dental Care to release any dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Cali Bay Dental Care.

Thank you for taking the time to read and understand our financial agreement and acknowledgements. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient Signature _____ Date _____

(Optional) I authorize **Cali Bay Dental Care** to disclose and discuss any information involving my treatment and/or medical records with the following:

Name _____ Relationship _____

Name _____ Relationship _____