Patient Information

Date ______________

☐Mr. ☐Mrs. ☐Ms. ☐Dr. Name ____
First MI Last Nickname

Marital Status: ☐Married ☐Single ☐Widowed ☐Minor Sex: ☐ Male ☐ Female

Birth Date _____/_____/_____ SS# ________-_______-________ Drivers License # ________________________

Phone (Home) ___________________ (Cell) ___________________ (Work) __________________ ext: ______

E-Mail Address ____

Address ____
Street or P.O. Box Apt# City State Zip

Place of Employment _________________________________ Occupation/Position ________________________

In case of emergency, please contact _________________________________ Tel: ________________________

Who were you referred by? ____

Who will be responsible for your account?

☐Self ☐Spouse ☐Father ☐Mother ☐ Other ______________ *(if self, skip to next section)*

Name ____________________________________ Birth Date _____/_____/_____ SSN______-______-______

Address ____
Street or P.O. Box Apt# City State Zip

Primary Dental Insurance Company

Name of insured ________________________________

Birth Date ____/____/____ SSN _____-_____-_____

If you have your insurance card, we can make a copy and you may skip this portion.

Ins. Carrier _____________________________________

Group # __________________ ID# _________________

Address _______________________________________
mail dental claims to:

Insurance Disclaimer

Tony M. Pacheco Jr., DDS is an **Out of Network** provider with all insurance carriers. We are happy to file your claims as a courtesy to you.

Payment of estimates will be collected at the time of treatment.

Signature of Patient _________________________
(Parent or Guardian if minor)

Date _________________

Dental History

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

What is your immediate concern? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

	YES	NO
Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) ________	❑	❑
Have you ever had complications from past dental treatment?	❑	❑
Have you ever had an unfavorable dental experience?	❑	❑
Have you ever had trouble getting numb or had any reactions to local anesthetic?	❑	❑
Did you ever have braces, orthodontic treatment, or had your bite adjusted?	❑	❑

GUM AND BONE

	YES	NO
Do your gums bleed or are they painful when brushing or flossing?	❑	❑
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	❑	❑
Have you ever experienced gum recession?	❑	❑
Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
Have you ever experienced a burning sensation in your mouth?	❑	❑
Have your teeth ever become loose on their own? (without injury)	❑	❑
Is there anyone in your family with a history of periodontal disease?	❑	❑

TOOTH STRUCTURE

	YES	NO
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	❑	❑
Do you frequently get food caught between any teeth?	❑	❑
Have you had any cavities within the past three years?	❑	❑
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	❑	❑
Do you feel or notice any holes on the biting surface of your teeth?	❑	❑

BITE AND JAW JOINT

	YES	NO
Do you have problems with your jaw joint?	❑	❑
Do you clench your teeth in the daytime or make them sore?	❑	❑
Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
Do you wear or have you ever worn a bite appliance?	❑	❑

SMILE CHARACTERISTICS

	YES	NO
Is there anything about the appearance of your teeth that you would like to change?	❑	❑
Have you ever whitened (bleached) your teeth?	❑	❑

Medical History

Name of Physician/specialty:

____

What is your estimate of your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:
An allergic reaction to:
- ☐ aspirin, ibuprofen, acetaminophen, codeine
- ☐ penicillin
- ☐ erythromycin
- ☐ tetracycline
- ☐ sulfa
- ☐ local anesthetic
- ☐ fluoride
- ☐ metals (nickel, gold, silver, _________)
- ☐ latex
- ☐ other ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
Heart problems, or cardiac stent (last 6 months)	☐	☐
Artificial heart valve, repaired heart defect (PFO)	☐	☐
Pacemaker or implantable defibrillator	☐	☐
History of infective endocarditis	☐	☐
Artificial prosthesis (heart valve or joints)	☐	☐

	YES	NO
Rheumatic or Scarlet fever	☐	☐
High or low blood pressure	☐	☐
A stroke (taking blood thinner)	☐	☐
Anemia or other blood disorder	☐	☐
Emphysema, sarcoidosis	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Thyroid, parathyroid disease, or calcium deficiency	☐	☐
High cholesterol or taking statin drugs	☐	☐
Diabetes (HbA1c=________)	☐	☐
Digestive disorders (i.e. gastric reflux)	☐	☐
Osteoporosis/osteopenia (i.e. taking bisphosponates)	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Head/neck injuries	☐	☐
Epilepsy, convulsions (seizures)	☐	☐
Neurological problems (ADD/ADHD)	☐	☐
Viral infections and cold sores	☐	☐
Any lumps/swelling in the mouth	☐	☐
Hives, skin rash, hay fever	☐	☐
Hepatitis (Type ________)	☐	☐
HIV/AIDS	☐	☐
Tumor/Abnormal growth	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Antidepressant medication	☐	☐

ARE YOU:		
Presently being treated for any other illness	☐	☐
Aware of a change in your health (i.e. fever, new cough)	☐	☐
Taking medication for weight management	☐	☐
Taking dietary supplements	☐	☐
Experiencing frequent headaches	☐	☐
A smoker, smoked previously, or used smokeless tobacco	☐	☐
FEMALE-taking birth control pills	☐	☐
FEMALE-pregnant	☐	☐

Patient's Signature **Date**

Doctor's Signature **Date**

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, collagen injections)

____

List all medications, supplements, and/or vitamins taken within the last two years:

DRUG	PURPOSE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAKE BE TAKING.

Financial Policy

Full payment is due at the time of service unless prior arrangements have been made. We accept cash, checks, VISA, MasterCard, Discover, and American Express.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company within 90 days of date of service.**

You will be responsible for all collection costs, attorneys' fees, and court costs.

Signature of Patient *(Parent or Guardian if minor)* X____ **Date X**______________

Usual and Customary Rates

Our fees are within the average range for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

Please be advised that we do not split billing for children whose parents are divorced. **The parent or guardian who brings the child to their appointment is responsible for payment.**

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at the time of services has been verified.

Broken Appointment Policy

We kindly request at least 24 hours advance notice if you are unable to keep your appointment. The office fee for a broken appointment is **$50 per hour of reserved time** and is to be paid *prior* to the scheduling of any new appointment.

I have read the above policy. I understand and agree to abide by the terms outlined.

Signature of Patient *(Parent or Guardian if minor)* X____ **Date X**______________

Authorization

The signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize to the doctor named of the benefits otherwise payable to me.

Signature of Patient *(Parent or Guardian if minor)* X____ **Date X**______________

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of Patient *(Parent or Guardian if minor)* X____ **Date X**______________