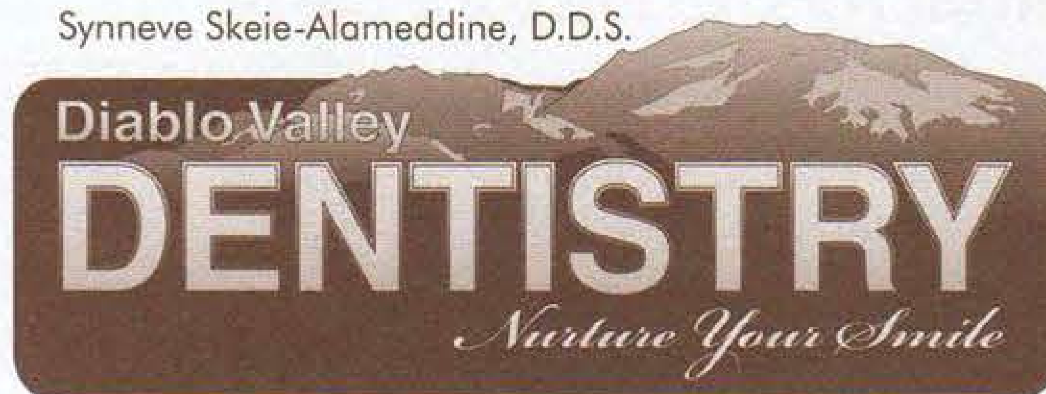
Welcome



1. About You

Today's Date: ______________________________ File#: ________

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called ________________ ❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____ SS#: ______________

Mailing Address: ____

____
CITY STATE ZIP

Home Phone#: (__________) ______________________________________

Cell Phone#: (__________) ______________________________________

E-mail Address: ____

Referred By: ____

Employer: ______________________________ How long? ________

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How Many? ______________

2. Insurance Info

Primary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone#: (__________) ____

Insured's ID# ____

Group# (Plan, Local or policy#): _______________________________

Insured's Name: ____

Relation: ____________________ Date of Birth: ____/____/____

Insured's employer: ____

Secondary Insurance: ____

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone#: (__________) ____

Insured's ID# ____

Group# (Plan, Local or policy#): _______________________________

Insured's Name: ____

Relation: ____________________ Date of Birth: ____/____/____

Insured's employer: ____

3. Account Info

Person ultimately responsible for Account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS# ____

Driver License#: ____

Work Phone #(__________) ______________________________________

Payment method: ❑ Cash ❑ Check

______________________________________ _____/_____

❑ Credit Card-Enter card # above (if accepted)

________ I hereby authorize assignment of my insurance rights
Initials and benefits directly to the provider for services rendered, I fully understand I am solely responsible for any balance not paid by my insurance company (if offered in this office)

4. In Event of Emergency

Whom should we contact: _______________________________________

Relation: ____

Home Phone #: (__________) _____________________________________

Work Phone#: (__________) ______________________________________

Cell Phone# (__________) _______________________________________

Who is your Medical Doctor? ___________________________________

Medical Doctor's Phone#: ______________________________________

Please continue on back →

Dental Health History Form

Today's Date: ______________

Patient Name: ____
FIRST LAST MI

Nickname ____

What are your goals in coming to our practice today? ____________________

What is important to you in a dentist or dental practice? ____________________

What has been you experience with the dentist in the past? ____________________

Date last radiographs (x-ray) and exam ____________________

Date of last hygiene continuing care appointment (*cleaning or periodontal maintenance*) ____________________

Former Dentist ____________________ **Phone** ____________________

Address: ____

____
CITY STATE ZIP

If you left your previous dentist, what are the reasons? ____________________

Have you had problems with prior dental treatment? ____________________

Are you experiencing any pain now? ❑ Yes ❑ No

If yes, please describe ____________________

Have you ever been pre-medicated with antibiotics for dental treatment? ❑ Yes ❑ No

If yes, why? ____________________

Have you been anxious about having dental treatment? ❑ Yes ❑ No

If yes, would you be comfortable sharing why? ____________________

Would you like to discuss this concern with the doctor to learn about relaxation options? ____________________

What concerns do you currently have with your oral health or smile? (*check all that apply*)

- ❑ Jaw joint pain
- ❑ Clenching or grinding teeth
- ❑ Discolored teeth
- ❑ Crowing/crooked teeth
- ❑ Missing teeth
- ❑ Space in between teeth
- ❑ Loose tooth/teeth
- ❑ Tooth shape of size
- ❑ Unhappy with appearance of teeth
- ❑ Overbite
- ❑ Underbite
- ❑ Uncomfortable bite
- ❑ Old fillings (*gold/silver*)
- ❑ Old Crowns
- ❑ Speech problems
- ❑ Too much gum tissue when I smile
- ❑ Tooth sensitivity to hot/cold or anything else
- ❑ Food gets caught in between teeth
  If yes, where? ____________________
- ❑ Difficulty chewing?
  If yes, where? ____________________
- ❑ Bad breath
- ❑ Other ____________________

Have you ever had orthodontic treatment? ❑ Yes ❑ No

If yes, when? ____________________

Have ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing or periodontal surgery? ❑ Yes ❑ No

If yes, when? ____________________

Have you whitened your teeth in the past? ❑ **Yes** ❑ **No**

If yes, what method? ____________________

Are you interested in learning more about the following? (*check all that apply*)

- ❑ Teeth whitening
- ❑ Orthodontic treatment
- ❑ Veneers
- ❑ Being sedated for your dental treatment
- ❑ Tooth-colored fillings
- ❑ Dental implants
- ❑ How to prevent periodontal disease
- ❑ At-home oral hygiene care
- ❑ Periodontal treatment during pregnancy
- ❑ Oral hygiene care for infants & toddlers

Confidential Health History Form

Today's Date: ____________

Patient Name: ____
FIRST LAST MI

Date of Birth ______________________

I. Circle appropriate answer (*Leave plank if you do not understand the question*)

1. **Yes / No** **Is your general health good?**
   If NO, explain ______________________________
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain ______________________________
3. **Yes / No** **Have you gone to the hospital, emergency room or had a serious illness in the last three years?**
   If YES, explain ______________________________
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain ______________________________
   Date of last medical exam? ______________ **Reason for exam** ______________
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain
   Date of last dental exam ______________ **Name of last treating dentist** ______________
6. **Yes / No** **Are you in pain now?**
   If YES, explain ______________________________

II. Have you experienced any of the following? (Please circle Yes or No for each)

Yes / No Chest pain (angina)
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Difficulty swallowing
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problem
Yes / No Blood in urine
Yes / No Difficulty sleeping
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Bruise easily
Yes / No Acid Reflux / Gerd
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Fever
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Sinus problems

III. **Have you had or do you have any of the following?** (Please circle Yes or No for each)

Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart attack, heart surgery
Yes / No Artificial joint
Yes / No Stomach problems or ulcers
Yes / No Heart Valve or transplant
Yes / No Heart Stint? When
Yes / No Heart Defect, Heart Murmur
Yes / No Sexually transmitted disease
Yes / No Anemia, blood disorder
Yes / No Emphysema or other lung disease
Yes / No Kidney of bladder disease
Yes / No Seizures
Yes / No Celiac Disease, gluten sensitivity
Yes / No Cosmetic surgery
Yes / No Sleep Apnea
Yes / No Hospitalization
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Recurrent Illnesses
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Rheumatic fever
Yes / No Arthritis, rheumatism
Yes / No Hardening of arteries
Yes / No High blood pressure
Yes / No Stroke
Yes / No Other Conditions or surgeries
Yes / No Eating disorders
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Asthma
Yes / No Hepatitis A,B,C
Yes / No Tuberculosis
Yes / No Herpes
Yes / No Radiation
Yes / No Canker or cold sore
Yes / No Skin Disease
Yes / No Liver disorder
Yes / No Eye disease
Yes / No Transplants

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV
Yes / No Anxiety
Yes / No Depression
Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle yes or no for each)

Yes / No Aspirin
Yes / No Darvon
Yes / No Codeine
Yes / No Latex
Yes / No Local anesthetic (Novocain, Xylocaine, Etc)
Yes / No Valium
Yes / No Demerol
Yes / No Penicillin
Yes / No Food
Yes / No Erythromycin
Yes / No Tetracycline
Yes / No Vicodin
Yes / No Percodan
Yes / No Nitrous oxide
Yes / No Metals of any kind

Yes / No Others ______________________________

V. Are you taking or have you taken any of the following in the last six months? *(Please circle Yes / No for each)*

Yes / No Recreational drugs or mood altering drugs
Yes / No Over-the-counter medications
Yes / No Weight loss medications
Yes / No Cortico Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax, etc.)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking ____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?**____________________________________

Yes / No **Are you nursing?**

Yes / No **Are you taking birth control pills?**

VII. All Patients (Please circle Yes or No for each)

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form.**

If YES, explain ____

Yes / No **Have you ever been pre-medicated with antibiotics for dental treatment?**

If YES, why____

Yes / No **Have you ever taken Fen-Phen?**

If YES, when ____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician,

Patient's Signature ____ Date____________________

Physician's Name ____ Phone Number____________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in completion or this form.

____ ____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Medical Updates

I have reviewed my Health History and confirm that is accurately states past and present conditions.

Date	Patient Signature	Changes in Health History	Dentist Initials

Synneve Skeie-Alameddine, DDS
Diablo Valley Dentistry
2630 Pleasant Hill Rd.
Pleasant Hill, CA 94523
925-932-2186

Acknowledgement of Receipt of Notice of New Privacy Practices

I am signing this document to indicate that I have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature of Patient or Legal Guardian

____
Date

Synneve Skeie-Alameddine, DDS
2630 Pleasant Hill Rd.
Pleasant Hill, CA 94523
925-932-2186

Office Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with at least 48 hours notice. This courtesy on your part will make it possible to give your appointment to another patient who needs our care. We are aware that unforeseen events sometimes require missing an appointment. After missing your second appointment without notifying us 48 hours in advance, we reserve the right to charge a broken appointment fee.

Please schedule only definite appointments.

I understand and have read the office cancellation policy.

_________________________________ _____________________

Patient Signature Date

Financial Policy

No Insurance
A treatment plan will be presented to you and payment is due at time of service. In special situations, other arrangements are possible, and the staff will assist you in this regard. We offer **Care Credit** payment plan as well.

For those with Insurance
We are happy to assist you in filing a claim on your behalf. However, Diablo Valley Dentistry makes no guarantee of estimated payment as this office is not affiliated with any insurance carriers; by signing this document, you *acknowledge* and *accept* full responsibility for payment. Your benefits are dictated by your individual insurance policy plan, and some services may not be covered by your insurance company. Doctors make their recommendations based on their knowledge of what is best for your oral health, not what your benefits will cover. *You* are responsible for payment regardless of any insurance company determination. Insurance co-pays and deductibles are to be paid at the time of service.

Should any issues arise concerning your account, you consent to the office contacting you by means of phone, email or text.

By signing this document you understand and agree to our Financial Policy as stated above. If you have any questions or concerns, please let us know BEFORE signing this document.

Signature of Patient or Responsible Party:_________________________ Date:________