Carmel Valley Dental

Welcome to Our Practice

Our mission is to help patients achieve a high level of dental health, which in turn improves the quality of their lives. We do this by our commitment and dedication to SERVICE, EDUCATION, ATTITUDE, and TEAM WORK.

PATIENT INFORMATION

Mr. Mrs. Dr. Ms. Miss Rev. I wish to be addressed as: _____Date_____

Patient Name_____ Date of Birth_____ Age_____

Address_____City,State,Zip_____

Home Phone_____ Cell _____Work _____

Email _____ SS# _____Marital Status _____

Employer _____ If Student, Name / City of School _____ FT PT

Spouse Name _____ Date of Birth _____

RESPONSIBLE PARTY

Responsible Party _____ Relationship _____

Address _____ City, State, Zip_____
(If different from above)

Home Phone_____ Cell _____Work _____

SS# _____ Date of Birth _____ Employer _____ Ins Y N

DENTAL INSURANCE INFORMATION

Primary Insurance _____ Phone _____Grp #_____

Subscriber _____SS / ID _____ Birthdate_____

Secondary Insurance _____ Phone _____Grp #_____

Subscriber _____SS / ID _____ Birthdate_____

Emergency Contact _____Phone _____

Whom may we thank for referring you ? _____

Carmel Valley Dental

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

This policy is to inform you of your financial obligation to **Carmel Valley Dental**

- All payment for services rendered are due and payable on the date of service. Carmel Valley Dental accepts the following methods of payment: cash, checks, debit cards, American Express, Discover, MasterCard, Visa, and CareCredit.

- As a courtesy to our patient's with insurance and in an effort to save you time, we are happy to complete and submit claims on your behalf. By having our office submit your claims it is important that you understand that this does not eliminate your financial obligation for treatments performed. In order for our office to submit your claims, it is your responsibility to provide the current dental insurance information in the form of an ID card at each visit. If the subscriber is someone other than you we require in advance, their date of birth, ID or Social Security Number, as well as the insurance company information in order to verify the coverage effective date and benefits.

- Carmel Valley Dental does not guarantee that your insurance company will pay for treatments you receive. Prior authorizations received are not a guarantee of payment. It is your responsibility to know all eligibility dates, and limitations including frequencies prior to scheduling your appointments. In the event your claims deny you are ultimately responsible. Carmel Valley Dental abides by American Dental Association guidelines and will not compromise our patients care to satisfy insurance requirements.

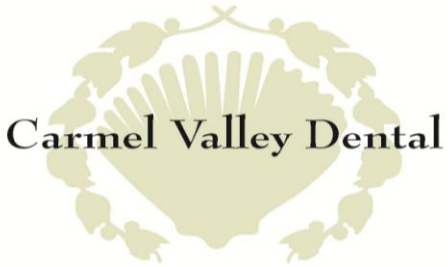
- Insurance payments are generally received within 30 days from the time of billing. In the event the insurance company has not paid at the end of the 30 day period you will be required to pay the entire balance. You will be responsible to seek any reimbursement from your insurance for claims older than 60 days. Carmel Valley Dental will provide any necessary documentation your insurance company requests in order to help answer questions that arise.

- I hereby authorize my insurance company to pay Carmel Valley Dental, Dr. Lindsay Bancroft, DDS and associates all benefits due me by reason of services described in the statements rendered and the above policy contract. I understand that I am financially responsible for charges not covered by this authorization.

- In the event of a returned check you will be subject to collection fees and possible finance charges at the rate of 1.5% per month.

By signing this agreement I am acknowledging that I am over 18 and I am assuming financial responsibility for myself or _____ for all dental charges performed by
Patient Name
Carmel Valley Dental, Lindsay Bancroft, DDS and Associates regardless of any dental insurance coverage. I also acknowledge that I have read and agree to the above financial policy and insurance assignment.

_____	_____	_____
Date	Signature of Patient or Responsible Party	Relationship to Patient



Informed Consent, Authorization

The Information that I have given today is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Carmel Valley Dental of any changes to my medical status, address, phone numbers, email, and insurance carriers.

I authorize the Carmel Valley Dental clinical staff to perform any necessary dental services, such as x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I further authorize Dr. Lindsay Bancroft, the Hygienists, and the Dental Assistants to perform any and all forms of treatment and administer medication and therapy allowed within their license parameters.

I understand that I will be presented with a treatment estimate prior to any previously diagnosed treatments are performed. I understand that I am responsible for payment of all services rendered regardless of insurance coverage. I am aware that my insurance may pay less than estimated and in that event I am responsible for all balances due. I am also aware that all payments are due on the day services are rendered. If other arrangements are necessary I must have a signed financial agreement in my record.
_____ (Initials)

I understand that Carmel Valley Dental requires 48 business hours / 2 business days notice (not including Saturdays and Sundays) for any cancelations or changes in your appointment. A charge of $50 per appointment may be placed. (Office determination)
_____ (Initials)

I acknowledge I have received, or have read Carmel Valley Dental's copy of the Dental Materials Fact Sheet dated May 2004 and the Hipaa notice or privacy act.

I authorize all employees and doctors of Carmel Valley Dental to release any information including any treatment rendered for my dependents or myself to third party payers and/or health practitioners. I acknowledge that I am over 18 years old.

_____ _____

Patient / Responsible Party Name (Printed) **Signature**

_____

Date

Lindsay A. Bancroft, D.D.S.

CONFIDENTIAL DENTAL HISTORY

Patient Name_____Date_____

Previous Dentist Name_____Phone_____

Email _____ Last Visit_____

What is your immediate dental concern? _____

Please circle YES or NO

1. Are you presently in pain?…… YES NO
   Jaw Face Gums Other
2. Is any part of your mouth sensitive to the following? …… YES NO
   Hot Cold Chewing or Pressure Sweet Sour Other
3. Do you have a burning sensation in your mouth? ……..…... YES NO
4. Are you troubled with dryness in your mouth? ……. YES NO
5. Do you have chronic neck aches? ……. YES NO
6. Do you have any pain or soreness around your eyes, ears or other parts of your face? ..…….. YES NO
7. Have you ever had periodontal treatment or gum surgery? ……..…… YES NO
8. Have you ever been informed that you have gum problems? …… YES NO
9. Do you notice that your gums bleed? …… YES NO
10. Does food catch between your teeth? …… YES NO
11. Are you aware of a bad taste or odor in your mouth? …… YES NO
12. Please indicate which items you use daily or as part of your home care?
    Soft-Bristle or Electric Toothbrush Proxi-Brush Rinses Floss Water Pik
    Stimudents Rubber Tip
13. Are you aware of any growths or swellings in your mouth? ……..…… YES NO
14. Do you have frequent cold sores, canker sores or fever blisters on your gums, cheeks or lips? YES NO
15. Are you aware of your jaw clicking, popping or making grating-like noises? ……. YES NO
16. Do your jaw muscles feel tired, stiff or painful, now or in the past? ..…… YES NO
17. Are you aware of clenching your teeth during the day or during sleep? ……..……. YES NO
18. Is there anything you'd like to change regarding the appearance of your teeth? ……..… YES NO
    Please explain _____
19. Are you interested in whitening your teeth? ….…….……..….. YES NO
20. Do you wear a removable denture or appliance? ……..…..… YES NO
21. Do you have or have you ever had any piercing for jewelry in or around the mouth? ..... YES NO
22. Do you feel nervous or anxious about dental treatment? ...……..…… YES NO
23. Have you ever had an adverse reaction to a local anesthetic? ……..……..…. YES NO
    Please explain_____
24. Have you ever had Dental Oral Surgery? ……..……. YES NO
25. Have you ever had Orthodontic treatment? …… YES NO
26. Do you have any condition that was not addressed that you feel is important for us to know? ….. YES NO
    Please explain

_____

_____ _____

Signature Date

Lindsay A. Bancroft, D.D.S.

CONFIDENTIAL MEDICAL HISTORY

This questionnaire is for your safety, complete answers will assist us in treating your individual needs.

Patient Name _____
Date_____

Name of
Physician_____

Specialty_____
Phone_____Email_____

1. Do you have a current medical problem? ……..…….…….. YES NO
   Please describe _____

2. Are you currently taking any medications? …….…….……. YES NO

Please indicate which ones.

- ❑ Heart Medication
- ❑ Blood Pressure Medication
- ❑ Nitroglycerine
- ❑ Inderal
- ❑ Antibiotics
- ❑ Sedatives
- ❑ Tranquilizers
- ❑ Pain Medications
- ❑ Cortisone (steroids)
- ❑ Thyroid
- ❑ Blood Thinners
- ❑ Birth Control Pills
- ❑ Other Medications
- ❑ Herbal Supplements
- ❑ Vitamins
- ❑ Alcohol _____ drinks per day
- ❑ Tobacco Products _____ per day _____ years

Name of Medication	Dosage	Purpose

Please describe the use of any drugs or discuss in complete confidentiality with the doctor. The use of recreational drugs, such as cocaine, stimulants and others may have a fatal interaction with local anesthetics or other common dental medications.

_____
___

3. Have you had an illness that required hospitalization? …….. YES NO
   Please describe _____
4. Have you ever had any excessive bleeding requiring special treatment? ……..…….. YES NO

Continued on pg 2…

5. Are you allergic, have you had an unusual reaction to, or have you been told not to take particular medications?

Y / N		Y / N		Y / N	
☐ ☐	Penicillin	☐ ☐	Aspirin	☐ ☐	Topical / Benzocaine
☐ ☐	Erthromycin	☐ ☐	Tylenol	☐ ☐	Septocaine
☐ ☐	Sulfa Drugs	☐ ☐	Ibuprofen	☐ ☐	Lidocaine
☐ ☐	Codeine	☐ ☐	Latex Allergy	☐ ☐	Epinephrine

6. Have you had or do you currently have any of the following:

Y / N		Y / N		Y / N	
☐ ☐	Heart Failure/Attack	☐ ☐	Asthma	☐ ☐	Hepatitis A, B, C or other
☐ ☐	Angina	☐ ☐	Hay Fever	☐ ☐	Liver Disease
☐ ☐	Heart Surgery	☐ ☐	Lung Disease	☐ ☐	HIV positive/AIDS (Circle)
☐ ☐	Pacemaker	☐ ☐	Sinus Trouble		
☐ ☐	Bypass	☐ ☐	Anemia	☐ ☐	Blood Transfusion
☐ ☐	Prosthetic Heart Valve	☐ ☐	Kidney Trouble	☐ ☐	Hemophilia
☐ ☐	Stroke	☐ ☐	Ulcers	☐ ☐	Cold Sores
☐ ☐	Rheumatic Fever	☐ ☐	Allergies or Hives	☐ ☐	Thyroid Disease
☐ ☐	Heart Murmur	☐ ☐	Diabetes	☐ ☐	Cancer
☐ ☐	High Blood Pressure	☐ ☐	Radiation Therapy	☐ ☐	Tumor
☐ ☐	Congenital Heart Lesions	☐ ☐	Chemotherapy	☐ ☐	Body Piercing
☐ ☐	Arteriosclerosis	☐ ☐	Arthritis	☐ ☐	Septicemia
☐ ☐	Mitral Valve Prolapse	☐ ☐	Osteoarthritis	☐ ☐	Phen-Fen
☐ ☐	Artificial Joint	☐ ☐	Gout/Gouty Arthritis	☐ ☐	Trauma to Head / Neck
☐ ☐	Emphysema	☐ ☐	Rheumatism	☐ ☐	Sleep Apnea
☐ ☐	Tuberculosis	☐ ☐	Glaucoma	☐ ☐	Do you snore?

7. Are you under the care of a psychologist or psychiatrist? …… YES NO
8. Are you under stress or nervous when it comes to any type of dental treatment? …… YES NO
9. Women: Are you pregnant now? …… YES NO
   Are you taking oral contraceptives? YES NO …… Are you taking any hormones?….. …… YES NO
11. Have you ever had elective surgery? …… YES NO
    Explain _____
12. Have you ever had reconstructive surgery, such as a knee, hernia, etc.?…….... YES NO
13. Have you any after effects from the above or any surgeries, such as fever, loss of blood, infection, blood transfusion or other complications? …… YES NO

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

_____ _____

Signature Date