# FOUNTAIN VALLEY DENTAL

## ACCOUNT INFORMATION AND FINANCIAL POLICY

PATIENT NAME______________________HOME PHONE #____________CELL PHONE #__________

DATE OF BIRTH______________AGE______________EMAIL______________________

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RESPONSIBLE PARTY (BILLING)____________________________DATE OF BIRTH______________

BILLING ADDRESS________________________________________________________

CITY______________STATE______________ZIP CODE____________________

CELL PHONE________________HOME PHONE____________EMAIL____________________

SOCIAL SECURITY #______________________EMPLOYER________________________

SPOUSES NAME__________________________DATE OF BIRTH______________________

SPOUSES EMPLOYER________________________________________

SPOUSES PHONE#__________________EMAIL______________________________

EMERGENCY CONTACT______________________PHONE #____________________

HOW DID YOU HEAR ABOUT US? (WE LIKE TO THANK THEM)____________________________

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PRIMARY INSURANCE:

INSURANCE SUBSCRIBER NAME____________________ EMPLOYER______________________

INSURANCE COMPANY NAME____________________PHONE #________________________

GROUP #________________________SUBSCRIBER ID#______________________________

RELATIONSHIP TO PATIENT____________________________________________________

SECONDARY INSURANCE:

INSURANCE SUBSCRIBER NAME_____________________EMPLOYER_____________________

INSURANCE COMPANY NAME__________________________PHONE#__________________

GROUP #______________________SUBSCRIBER ID#____________________________

RELATIONSHIP TO PATIENT________________________________________________

(please turn over)

IMPORTANT FINANCIAL INFORMATION*

Fountain Valley Dental accepts all major credit cards, personal checks, debit cards, and cash. Credit cards can be left in our secure file for automatic payments or we will assist you in applying for third party deferred interest financing for six months. As most insurance companies pay a percentage of fees for dental treatment, we ask you to pay your percent copayment at the time of each visit. We will estimate this amount using the information your insurance company provides to us. Any difference will be billed and/or returned to you. As a courtesy, we will bill your insurance, so please make certain all your insurance information is current and correct.

Generally, these are the steps you can expect for charges sent to insurance:

STEP ONE: Your ***estimated*** financial responsibility is due before treatment
STEP TWO: Insurance processes your claim and issues payment. (If applicable)
STEP THREE: Payment of final balance. As a convenience to you, we will send you a statement for balance due.

**AUTHORIZATION FOR TREATMENT**

I hereby authorize Dr. Ben Whitted, Dr. Brenden Bell, dental hygienists and assistants, as directed by the doctors, to perform any and all treatment, medication, and therapy as may be indicated in connection with my dental care or the dental care of my minor dependants. I further authorize and consent that the doctors choose and employ such assistance as he deems fit. Full disclosure of options and diagnosis will be discusses prior to treatment.

**OFFICE HOURS**

Our regular office hours are by appointment Monday through Saturday from 8-5. Any afterhours emergency visits will incur a charge over and above the cost of treatment. All fees are due at the time of service. We do not accept short-notice appointment changes after hours by telephone. Please call during business hours.

**AUTHORIZATION AND RELEASE**

I authorize Fountain Valley Dental to release any information, including diagnosis and records of any treatment or examination rendered to me or my minor dependent to third party payers, my insurance, and/or other health practitioners. I authorize and assign benefits from my insurance company(s) to be paid directly to Fountain Valley Dental. I agree to be responsible for all treatment fees, insurance deductibles, and copayments for treatment rendered to me or my minor dependants.

Your appointment will be set aside just for you. In the unlikely event you are unable to keep your appointment, please call us immediately.

SIGNED________________________________________

PATIENT/PARENT/ORGUARDIAN DATE____________________________

## Medical Health History

**PATIENT NAME:**______________________________ **DATE:**______________

Name of Medical Doctor: ______________________________ Date of Last Visit: ______________

**Please check Yes or No for those that apply to you.**

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Anemia | ☐ | ☐ | Emphysema | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Seizures |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Liver Disease | ☐ | ☐ | Stomach Problems |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Fainting | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Stroke |
| ☐ | ☐ | Artificial Joints | ☐ | ☐ | Glaucoma | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Thyroid Disease |
| ☐ | ☐ | Asthma | ☐ | ☐ | Heart Conditions | ☐ | ☐ | Nervousness / Depression | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | Blood Disease | ☐ | ☐ | Heart Lesions | ☐ | ☐ | Pacemaker | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Bruise Easily | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Prophylactic Antibiotics | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Cancer | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Periodontal Disease | | | ***Women Only*** |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Hepatitis: A B C | ☐ | ☐ | Radiation (Head / Neck) | ☐ | ☐ | *Birth Control* |
| ☐ | ☐ | Diabetes | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | *Nursing* |
| ☐ | ☐ | Dizziness | ☐ | ☐ | HIV Positive | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | *Pregnant*: |
| ☐ | ☐ | Drug Addiction | ☐ | ☐ | Jaundice | ☐ | ☐ | Rheumatism | | | *Delivery Date*: __________ |

**Do you have any of the following drug allergies?**

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Aspirin | ☐ | ☐ | Latex | ☐ | ☐ | Percodan |
| ☐ | ☐ | Codeine | ☐ | ☐ | Anesthetic | ☐ | ☐ | Penicillin |
| ☐ | ☐ | Darvon | ☐ | ☐ | Nitrous Oxide | ☐ | ☐ | Antibiotics |
| ☐ | ☐ | Erythromycin | ☐ | ☐ | Sulfa | ☐ | ☐ | Other Allergies |

Please list other allergies.
______________________________
______________________________
______________________________

**Please check any of the following drugs you have used at any time:**

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Fosamax | ☐ | ☐ | Didronel | ☐ | ☐ | Zometa | ☐ | ☐ | Boniva |
| ☐ | ☐ | Aredia | ☐ | ☐ | Actonel | ☐ | ☐ | Skelid | ☐ | ☐ | Bisphosphonates |

**Please list any medications you are currently taking:**

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Any illness not marked above? Please explain.______________________________

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify FOUNTAIN VALLEY DENTAL of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold FOUNTAIN VALLEY DENTAL or its employees liable in the event of death or injury.

Signature (Patient / Guardian) ______________________ Date: __________ Staff Signature: ______________

**Please check Yes or No for those that apply to you.**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Sensitivity to: Hot Cold Sweet | ☐ | ☐ | Bleeding, Swollen or Irritated Gums |
| ☐ | ☐ | Chipped / Broken Teeth | ☐ | ☐ | Dissatisfied With Appearance of My Teeth |
| ☐ | ☐ | Crooked or Tipped Teeth | ☐ | ☐ | Frequent Headaches |
| ☐ | ☐ | Loose Teeth | ☐ | ☐ | Jaw Joint Pain |
| ☐ | ☐ | Missing or Spaces Between Teeth | ☐ | ☐ | Grinding or Clenching Teeth |
| ☐ | ☐ | Catch Food Between Teeth | ☐ | ☐ | Uncomfortable or Uneven When I Bite My Teeth Together |
| ☐ | ☐ | Dry Mouth or Constantly Thirsty | ☐ | ☐ | Clicking or Popping of Jaw |
| ☐ | ☐ | Smoke or Use Chewing Tobacco | ☐ | ☐ | Difficulty Opening or Chewin |

**Please check Yes or No if you have, or have had any of the following?**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | Dentures or Partials | ☐ | ☐ | Veneers |
| ☐ | ☐ | Braces or Clear Braces | ☐ | ☐ | Jaw Surgery |
| ☐ | ☐ | Periodontal Disease or Gum Treatments | ☐ | ☐ | Root Canals |
| ☐ | ☐ | Fixed Bridge | ☐ | ☐ | Sleep Apnea |
| ☐ | ☐ | Dental Implants | ☐ | ☐ | C-PAP Machine or Oral Sleep Appliance |
| ☐ | ☐ | Crowns | ☐ | ☐ | Fear or Anxiety About Dental Treatment |

**On a scale of 1 – 10, with 10 being the highest rating:**

How important is your dental health to you? . . . . . . . 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? . . . . . . . 1 2 3 4 5 6 7 8 9 10

**If I could change my smile, I would:**

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

If you could whiten your teeth for a investment anyone could afford, would you be interested? ☐ Yes ☐ No

**If this is your first time in our office please answer the following:**

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

(Staff Use Only)

Date Reviewed and Initials: ________ Date Reviewed and Initials: ________ Date Reviewed and Initials: ________

Date Reviewed and Initials: ________ Date Reviewed and Initials: ________ Date Reviewed and Initials: ________