DEMKO BROCKETT DENTAL
2654 Fourth Ave, San Diego, CA 92103 I Phone: (619)234-7493 I Email: demkobrockett@gmail.com

General Patient Information

Patient Name: _____ DOB: ___/___/_____ Gender: M F
SSN: ____-____-_____ Email Address: _____ Marital Status: S M W D

Residence Address: _____
City State Zip

Home Phone#: _____ Mobile#: _____ Bus. #: _____

Employer: _____ Occupation: _____
Business Address: _____
City State Zip

If patient is Child/Dependent:
Who is legally responsible?: _____ Relationship to dependent: _____
School Grade: _____

How did you hear about our practice?:_____

If you are completing this form for the patient, what is your relationship to that person?
Your Name:_____ Relationship: _____

PRIMARY DENTAL INSURANCE

If you have specific questions about treatment fee portions covered by your dental benefit program, please ask us to perform a benefit pre-authorization/pre-determination check.

Policy Subscriber Name: _____ Policy Subscriber SSN: _____
Patient relationship to policy owner: _____ Policy Subscriber DOB: ____/____/_____
Insurance Carrier: _____ Insurance Phone#: _____
Member ID #: _____ Group Number: _____

SECONDARY DENTAL INSURANCE (If Applicable)

Policy Subscriber Name: _____ Policy Subscriber SSN: _____
Patient relationship to policy owner: _____ Policy Subscriber DOB: ____/____/_____
Insurance Carrier: _____ Insurance Phone#: _____
Member ID #: _____ Group Number: _____

Emergency Contact

1. Name: _____ Relationship: _____ Phone#: _____ ☐Home ☐Mobile
2. Name: _____ Relationship: _____ Phone#: _____ ☐Home ☐Mobile

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable law. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient/Parent/Representative Signature: _____ Date: _____

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Patient Name: _____ Today's Date:_____

Health History Form

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*
(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
1. Do you have any of the following diseases or problems:			
Active Tuberculosis?	☐	☐	☐
Persistent cough greater than a 3 week duration?	☐	☐	☐
Been exposed to anyone with tuberculosis?	☐	☐	☐

STOP: If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Primary Physician

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: _____
Address: _____
City State Zip
Date of last physical exam:_____ Phone#: (____)_____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.
(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
2. Are you in good health?	☐	☐	☐
3. Has there been any changes in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?_____			
4. Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
5. **Are you currently taking or have you recently taken any prescription(s) or over the counter medicine(s)?**	☐	☐	☐
If so, please list **ALL**, including vitamins, natural or herbal preparations and/or dietary supplements. (More room at bottom of page) _____			
_____			
_____			
_____			
6. **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
If so, date:_____ If yes, have you had any complications?_____			
7. Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia Boniva, Reclast, Prolla) for osteoporosis or Paget's disease?	☐	☐	☐
8. Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, metastatic cancer?	☐	☐	☐
Date Treatment began: _____			
9. Do you wear contact lenses?	☐	☐	☐

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	Yes	No	DK
10. Do you use controlled substances (drugs)?	☐	☐	☐
11. Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (*circle one*): VERY / SOMEWHAT / NOT INTERESTED			
12. Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much do you typically drink in a week? _____			

WOMEN ONLY-Are you:	Yes	No	DK
13. Currently Pregnant?	☐	☐	☐
If so, number of weeks: _____			
14. Taking birth control pills or hormonal replacement?	☐	☐	☐
15. Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:

To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics: _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics: _____	☐	☐	☐

	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other: _____	☐	☐	☐

Please mark (x) to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
*Angina	☐	☐	☐
*Cardiovascular disease	☐	☐	☐
*Arteriosclerosis	☐	☐	☐
*Congestive heart failure	☐	☐	☐
*Damaged heart valves	☐	☐	☐
*Heart attack	☐	☐	☐
*Heart murmur	☐	☐	☐
*Pacemaker	☐	☐	☐
*Mitral valve prolapse	☐	☐	☐
*Stroke	☐	☐	☐
*Rheumatic heart disease	☐	☐	☐
*Other congenital heart defects: _____	☐	☐	☐
*Hepatitis, jaundice or liver disease	☐	☐	☐
*Osteoporosis	☐	☐	☐
*Asthma	☐	☐	☐

	Yes	No	DK
*Low blood pressure	☐	☐	☐
*High blood pressure	☐	☐	☐
*Abnormal bleeding	☐	☐	☐
*Anemia	☐	☐	☐
*Blood Transfusion	☐	☐	☐
If yes, date: _____			
*Hemophilia	☐	☐	☐
*Autoimmune disease	☐	☐	☐
*Arthritis	☐	☐	☐
*Rheumatoid Arthritis	☐	☐	☐
*Glaucoma	☐	☐	☐
*Epilepsy	☐	☐	☐
*Fainting spells or seizures	☐	☐	☐
*Lupus	☐	☐	☐
*Vertigo	☐	☐	☐
*Bronchitis	☐	☐	☐
*Emphysema	☐	☐	☐

	Yes	No	DK
*Sinus trouble	☐	☐	☐
*Tuberculosis	☐	☐	☐
*Chest Pain upon exertion	☐	☐	☐
*Chronic Pain	☐	☐	☐
*Sleep Disorder	☐	☐	☐
*Do you snore?	☐	☐	☐
*PTSD	☐	☐	☐
Specify: _____			
*Neurological Disorders	☐	☐	☐
*Recurrent Infections	☐	☐	☐
Type of infection: _____			
*Diabetes Type I or II	☐	☐	☐
*Eating Disorder/ Malnutrition	☐	☐	☐
*Ulcers	☐	☐	☐
*Persistent swollen glands in neck	☐	☐	☐
*Gastrointestinal disease	☐	☐	☐
*G.E. Reflux/persistent heartburn	☐	☐	☐
*Severe headaches/migraines	☐	☐	☐
*Severe or rapid weight loss	☐	☐	☐
*Thyroid problems	☐	☐	☐
*Kidney problems	☐	☐	☐
*Night Sweats	☐	☐	☐
*Excessive Urination	☐	☐	☐
*Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
*AIDS or HIV infection	☐	☐	☐
*Sexually Transmitted Disease	☐	☐	☐

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Has a physician or previous dentist recommended that you take antibiotics prior to your dental visit? Yes ☐ No ☐ DK ☐
Name of Physician or dentist making recommendation: _____ Phone#:_____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain: _____

Dental Information

	Yes	No	DK		Yes	No	DK
1. Do your gums bleed when you brush or floss?	☐	☐	☐	9. Do you have earaches or neck pains?	☐	☐	☐
2. Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	10. Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
3. Is your mouth dry?	☐	☐	☐	11. Do you brux or grind your teeth?	☐	☐	☐
4. Have you had any periodontal (gum) treatments?	☐	☐	☐	12. Do you have sores or ulcers in your mouth?	☐	☐	☐
5. Have you ever had orthodontic (braces) treatments?	☐	☐	☐	13. Do you wear dentures or partials?	☐	☐	☐
6. Have you had any problems associated with previous dental treatment?	☐	☐	☐	14. Do you participate in active recreational activities?	☐	☐	☐
7. Is your home water supply flouridated?	☐	☐	☐	15. Have you ever had a serious injury to your head or mouth?	☐	☐	☐
8. Do you drink bottled or filtered water?	☐	☐	☐	16. Are you currently in experiencing dental pain or discomfort?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY				If so, describe:_____			

17. Date of your last dental exam: _____ What was done at that time: _____
18. Date of last dental x-rays: _____

19. What is the reason for your dental visit today: _____

20. How do you feel about your smile? _____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments:_____

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Radiographs Acknowledgement

Practicing dentistry to the proper standard of care requires both periodic clinical examination AND periodic radiographic examination ("x-rays") of the oral tissues. Using the American Dental Association radiographic guidelines as a benchmark, we will evaluate your dental & periodontal risk factors to determine your evidence-based appropriate frequency for diagnostic radiographs.

Please share any concerns regarding diagnostic radiographs with your provider, but understand diagnostic radiographs are not "negotiable" as a patient of our practice. Since you are charging us with responsibility for your oral health, we must have the proper information ("x-rays") to deliver oral healthcare services to you according to dentistry's standard of care. Below is our typical conservative diagnostic radiograph schedule which applies to the majority of patients:

Full mouth series - "the big set"	Once every 5 years
Bitewings - "the small set"	Once every 18 months
Periapical, Bitewing, CBCT, Pano	Problem focused x-rays as you may need for specific new or chronic issues

☐ **I have read, acknowledged, and had a chance to ask questions about the above dental radiographic treatment information; I understand and agree to its content.**

Patient Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____

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PAYMENT POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. All dental services performed without previous financial arrangements must be paid for at the time services are performed. Patients with dental insurance understand they are ultimately financially responsible for all dental services rendered regardless of insurance claim payment status. The practice depends upon reimbursement from patients for the costs incurred in their care. The office submits insurance claims on behalf of the patient. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. Patients who have questions about their bills may call and speak with our Front Office Team Member during business hours.

CANCELLATION POLICY

I understand I will be charged a fee for no-showing to an appointment or canceling appointments with less than 48 business hours (2 business days) notice.

Fees = [$60 for 1 hour appointment] or [$120 for 2+ hours appointment].

Arriving at an appointment over 20 minutes late disrupts other patients receiving dental services and is considered a no-show. If you find yourself ill on short notice and alert us prior to the appointment, we will reconsider the cancellation fee. Patients with a history of no-shows and cancellations may be required to pre-pay for treatment to secure an appointment.

MUTUAL RESPECT POLICY

As a professional dental services provider we will treat you with respect. We also expect our patients to respect our entire practice staff at all times. We do not tolerate verbal abuse, physical abuse, profanity, or sexual harassment, among others.

COMPREHENSIVE CARE

Our practice practices comprehensive dental care. We work together with our patients to prioritize patients' needed dental treatment based on what we believe is best for your overall oral health. Some complex conditions may not be treatable at this practice requiring patients to be referred to a specialist or emergency medical services provider.

☐ **I have read the above conditions of treatment & payment, and I agree to their content. I grant my permission to you, or your assignee, to telephone, email, or text me to discuss this policy or my treatment.**

Patient Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____

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AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate for a comprehensive evaluation.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian (responsible party):

Signature: _____ **Date:** _____

Relationship to patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in my treatment.
-Obtain payment from third-party payers.
-Conduct normal health care operations such as quality assessments and accreditation.
-I understand that in the normal course of providing healthcare my PHI may be transmitted via electronic messaging including, but not limited to, FAX, email, and telephone messaging.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ **Date:** _____

Relationship to patient: _____