Park Place Dental of San Mateo

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____ Date_____ Patient No._____
Address_____City_____State_____Zip_____
Date of Birth_____ Social Security #:_____
Primary phone#_____ Secondary phone#_____
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Either
Email Address: _____
Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
You or your parent's employer_____Occupation_____
Business Address_____ City_____ State_____ Zip_____
Spouse's or parent's name_____ Workplace_____ Work phone#_____
If you are a student, name of school/college_____ City_____ State_____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone#_____

Responsible Party

Name of person responsible for this account?_____
Relationship to patient_____ Phone#_____
Address_____ City_____ State_____ Zip_____
Name of employer_____ Work phone#_____

Dental Insurance

Primary Carrier

Insurance Company_____
Address_____
City_____ State_____ Zip_____
Tel_____ Group #_____
Employer Name_____
Insured's Name_____
Insured's Date of Birth_____
Insured's SSN/ID#_____
Relationship to Patient_____

Secondary Carrier

Insurance Company_____
Address_____
City_____ State_____ Zip_____
Tel_____ Group #_____
Employer Name_____
Insured's Name_____
Insured's Date of Birth_____
Insured's SSN/ID#_____
Relationship to Patient_____

Dental History

Name: _____
Former Dentist_____
Reason for today's visit_____
Date of last exam_____ Date of last dental x-rays_____
Please check if any of the following conditions apply to you:

____ Bad Breath
____ Bleeding Gums
____ Clicking or popping jaw
____Food collection between teeth
____Grinding teeth
____loose teeth or broken fillings
____Periodontal treatment
____Sores or growths in your mouth
____Sensitivity to hot
____Sensitivity to sweets
____Sensitivity when biting
____Sensitivity to cold

Medical History

Patient Name_____

Physician Name_____Phone_____

Date of last visit_____ Reason_____

Please list all medications you are currently taking: _____

Have you ever had an allergic or adverse reaction to any medication or substance? Yes No

If yes, list medication_____

Describe reaction_____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Do you have a history of the following? Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No
High Blood Pressure	Yes	No
Chest Pain	Yes	No
Congenital Heart Disease	Yes	No
Heart Murmur	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Heart Pacemaker	Yes	No
Rheumatic Fever	Yes	No
Arthritis/Rheumatism	Yes	No
Cortisone Medication	Yes	No
Swollen Ankles	Yes	No
Stroke	Yes	No
Diet (Special/Restricted	Yes	No
Artificial Joints (Hip/Knee)	Yes	No
Kidney Trouble	Yes	No
Psychiatric/Psychological Care	Yes	No
Ulcers	Yes	No
Anorexia/Bulimia	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Glaucoma	Yes	No
Contact Lenses	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No

Tuberculosis	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Latex Sensitivity	Yes	No
Sinus Trouble	Yes	No
Allergies or Hives	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Tumors/Cancer	Yes	No
Hepatitis A or B	Yes	No
Hepatitis C	Yes	No
STD	Yes	No
A.I.D.S	Yes	No
HIV Positive	Yes	No
Cold Sores	Yes	No
Blood Transfusion	Yes	No
Hemophilia	Yes	No
Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No
Yellow Jaundice	Yes	No
Epilepsy/Seizures	Yes	No
Neurological Disorder	Yes	No
Fainting/Dizzy Spells	Yes	No
Nervous/Anxious	Yes	No

Dentist Signature_____ Date_____

Authorization

I certify that I have read and understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Patient/ Parent/Guardian Signature Date

Consent For Use and Disclosure of Health Information (HIPAA)

Section A: Patient Giving Consent

Name of Patient:_____

(PRINT)

Section B: PATIENTS PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: 650-627-8191

Park Place Dental

Right to Revoke: You will have the right to revoke this Consent at any time by providing our office with a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

* If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Park Place Dental
of San Mateo

Hello! Welcome to Park Place Dental. Thank you for choosing us as your dental provider. We know there are other dentists in the area and we are honored by your trust. Our commitment is to provide you with the highest standard of care available. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible. Please read through this form, sign it and give it to the front desk before seeing the dentist.

Dental Insurance

As a service to our patients, we will assist you in billing your insurance carrier. In order to provide that service we must have all of your current insurance information. You are responsible for notifying our office of any changes in your insurance, the portion of the charges not covered by insurance are due in full at the time of the appointment.

Your insurance policy is a contract between you and your insurance company. As a dental provider, we are not party to that agreement. Insurance benefits vary from policy to policy. Please be aware that after 90 days, full payment is due on your dental treatment whether or not your dental insurance has made payment. It is the patient's responsibility to follow up with your insurance company if they have not paid your claims within 90 days of the date of service. After 90 days any unpaid account balance will be your responsibility.

Underage Patients

An adult must accompany patients under 18 years of age. Payment for services of the treatment of minors is the responsibility of the adult accompanying that minor.

Missed Appointments

We reserve the right to bill a patient $75 for a missed appointment unless we are given a 48-hour advance notice. If you miss an appointment without notifying the office, $75 will be charged to you directly, not your insurance carrier and will be your direct responsibility. No future appointments can be scheduled until the fee has been paid. Please remember that the dental staff has set aside a designated time for your particular type of treatment. The charge is subject to change at any time.

X-Rays

In order to provide the minimal standard level of care, it is necessary for us to have a complete set of diagnostic x-rays for a new patient. If you have had this done at a different office within the past 12 months, you can request that they be forwarded to our office. If not, we do require they be done before providing any definitive treatment.

___ I give consent to take x-rays as is clinically necessary.

___I do not give consent for any x-rays due to the following reasons:

1. I authorize the release of any information necessary to process my insurance claim
2. I authorize payment of dental benefits to the provider of services at Park Place Dental.

I understand and agree to this financial policy.

Patient/ Guardian (signature):_____ Date:_____

Patient/ Guardian (print):_____ relationship:_____