Anthony T. Fernandez, DDS, Inc.

Patient Information Form

Today's Date_____

Patient Name: First _____ MI ___ Last _____

I prefer to be called or addressed as: _____

Date of Birth_____ **Place of Birth**_____

☐**Single** ☐**Married** ☐**Partnered** ☐**Divorced** ☐**Separated** ☐**Widowed**
☐**Male** ☐**Female** ☐**Nonbinary**

Address: Street_____

City/State/Zip_____

Phone: Mobile_____Home_____Work_____

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I do not consent to receiving any information via email. I understand that I can change my mind & provide consent later.

☐ I consent and accept the risk receiving information via email. I understand I can withdraw my consent later.

☐ I consent to receiving only appointment reminders via email. I understand I can withdraw my consent later.

☐ I consent to receiving appointment reminders via text message. Number: _____

Email: _____

Social Security #_____ **Drivers Lic. #** _____

Employer: _____ Occupation_____

Work Address: _____

Emergency Contact: Name _____ Relationship to Patient _____

Emergency Phone #1 _____ Emergency Phone #2 _____

Is the patient a minor? ☐**Yes** ☐**No** **Student?** ☐**Yes** ☐**No** School _____

Minor's Residency ☐ Both Parents ☐ Mom ☐Dad ☐Stepparent ☐ Shared ☐Guardian

Minor's Alternative Address: _____

How did you hear about our office? _____

Office Financial Policy & Consent Form

Name of Responsible Party: First _____ Last_____
Date of Birth _____ Social Security # _____
Billing Address _____ Phone _____
Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Dental Insurance / Benefit Plan Information ☐ No insurance
Primary Dental Plan Name _____ Phone _____
Address of Insurance Co._____
Name of Insured _____ SS# _____ DOB _____
Employer _____ Group Number _____ ID # _____
Relation of Insured to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Secondary Dental Plan Name _____ Phone _____
Address of Insurance Co. _____
Name of Insured _____ SS# _____ DOB _____
Employer _____ Group Number _____ ID # _____
Relation of Insured to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice. Payment of your bill is considered a part of your treatment.

Payment Terms: Payment is due at the time services are rendered. Treatment plans and financial arrangements are discussed before performing any treatment with our practice. Patients have the right to know about their treatment options and the cost of that treatment in advance. We accept the following forms of payment - Checks, Debit Cards, Credit Cards, Cash. There is a **$25 fee** for returned checks.

Dental Benefit Plans: Your dental benefit (dental insurance) is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. Some or all the dental services provided to you may be non-covered services according to your insurance plan. As a courtesy, we will help you submit your insurance claims.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment; it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we require 48-hour notice to reschedule an appointment. With less than 48-hour notice, there is a **fee of $75.00**. A deposit to reserve an appointment time again may be required. To serve all our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice.

Consent and Authorizations: **Please read, then initial all lines. Sign and date at bottom.**

- I authorize the release of information necessary to process my dental benefit claims. _____ (initial)
- I have read the above and agree to the financial and scheduling terms. _____ (initial)
- I consent to have radiographs, photographs, video images, study models, or any other diagnostic aids taken to diagnose my oral health needs. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon in order to provide proper oral care. I consent to the limited sharing of my personal health information with laboratories and other health professionals under HIPAA regulations. I consent to the use of anesthetics and other medications deemed necessary for my dental care. I understand that receiving dental care involves certain risks as well as benefits. I have the right to know about the risks, benefits, and options regarding my dental care. The information I have given is correct to the best of my knowledge. _____ (initial)
- I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)
- I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding the Fact Sheet. _____ (initial)

Signature _____ Date _____

Health History & Information

Today's Date: _____

Patient Name: (print) _____ **DOB**: _____**Phone**: _____

The practice of dentistry involves treating the whole person. If the dentist determines that a medical or dental consultation is needed, I authorize the dentist to contact my physician(s) or other dentists. _____ **(initial)**

Primary Care Physician: _____ ☐**Kaiser #**_____

Physician's Phone # _____ **Address:** _____

Please mark (☒) the appropriate answer

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? _____

3) ☐**Yes /** ☐**No** Have you gone to the hospital or emergency room, had surgery or serious illness in the last 3 years?

4) ☐**Yes /** ☐**No** Are you being treated by a physician now? **Date of last medical exam:** _____

5) ☐**Yes /** ☐**No** Have you had a problem with prior dental treatment? **Date of last dental exam:** _____

6) ☐**Yes /** ☐**No** Are you in pain now? **Name of last dentist** _____

Have you had or do you have any of the following? (Please mark (☒) Yes or No for each)

1) ☐**Yes /** ☐**No** ALLERGIES**:**
- ☐ latex
- ☐ penicillin / other antibiotics_____
- ☐ local / dental anesthetics
- ☐ other meds: _____
- ☐ metals (e.g. nickel)
- ☐ pollen / hay fever
- ☐ food: _____
- ☐ other: _____

2) ☐**Yes** ☐**No** ANEMIA
3) ☐**Yes** ☐**No** ARTHRITIS
4) ☐**Yes** ☐**No** ASTHMA
5) ☐**Yes** ☐**No** BACK / SPINE PROBLEM
6) ☐**Yes** ☐ **No** BLEEDING PROBLEMS
7) ☐**Yes** ☐**No** CANCER / TUMORS
8) ☐**Yes** ☐**No** CHEMICAL DEPENDENCY
9) ☐**Yes** ☐**No** CHEMOTHERAPY
10) ☐**Yes** ☐**No** CIRCULATORY PROBLEM
11) ☐**Yes** ☐**No** CORTISONE / STEROIDS
12) ☐**Yes** ☐**No** DIABETES (TYPE _____)
13) ☐**Yes** ☐**No** EATING DISORDER
14) ☐**Yes** ☐**No** EMPHYSEMA
15) ☐**Yes** ☐**No** EPILEPSY / SEIZURES
16) ☐**Yes** ☐**No** EYE / VISION PROBLEMS
17) ☐**Yes** ☐**No** FAINTING
18) ☐**Yes** ☐**No** GASTROINTESTINAL ISSUES (ACID REFLUX / GERD)
19) ☐**Yes** ☐**No** HEART PROBLEMS
20) ☐**Yes** ☐**No** HEPATITIS (TYPE ☐**A** ☐**B** ☐**C** ☐**D**)
21) ☐**Yes** ☐**No** HERPES / SHINGLES
22) ☐**Yes** ☐**No** HIGH / LOW BLOOD PRESSURE (LIST MEDS BELOW)
23) ☐**Yes** ☐**No** HIV / AIDS (CD4 / T-cell COUNT BELOW 200? ☐YES ☐NO)
24) ☐**Yes** ☐**No** IMMUNE SUPPRESSED / MRSA INFECTION
25) ☐**Yes** ☐**No** KIDNEY / URINARY PROBLEMS
26) ☐**Yes** ☐**No** LIVER PROBLEMS (CIRRHOSIS, etc.)
27) ☐**Yes** ☐**No** PACEMAKER / DEFIBRILLATOR
28) ☐**Yes** ☐**No** (WOMEN): PREGNANT OR TRYING? (DUE DATE _____)
29) ☐**Yes** ☐**No** (WOMEN): NURSING?
30) ☐**Yes** ☐**No** PSYCHIATRIC / ANXIETY / DEPRESSION ISSUES
31) ☐**Yes** ☐**No** RADIATION TREATMENT (EXPLAIN _____)
32) ☐**Yes** ☐**No** SEXUALLY TRANSMITTED INFECTION / HPV
33) ☐**Yes** ☐**No** SINUS / TONSIL / EAR PROBLEMS
34) ☐**Yes** ☐**No** SKIN PROBLEMS (_____)
35) ☐**Yes** ☐**No** SLEEP APNEA / SNORING
36) ☐**Yes** ☐**No** STROKE, NERVE / NEUROLOGIC ISSUE
37) ☐**Yes** ☐**No** THYROID / ENDOCRINE ISSUE (HYPO / HYPER)
38) ☐**Yes** ☐**No** TOBACCO - ☐PRESENT ☐PAST, ☐SMOKE / ☐CHEW/ ☐VAPE
39) ☐**Yes** ☐**No** TUBERCULOSIS
40) ☐**Yes** ☐**No** OTHER**:** _____

☐**YES** ☐**NO** **Do you need antibiotics for dental procedures because of heart valve surgery, previous heart infections, congenital heart disease, heart defect or shunt surgery, heart transplant, or immunosuppression?**

***Please list current medications, including prescription, over the counter, herbal, or supplements:** ☐LIST ATTACHED

REMARKS:

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 medications.

Patient / Guardian Signature _____ **Date** _____ **DOCTOR'S INITIALS** _____

MEDICAL UPDATES: (I have reviewed my health history and confirm that it accurately states past and present conditions.)

Date	Patient Initials	Changes to Health History	Doctor's Initials
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___
_____	_____	_____	___

Dental History & Risk Assessment **Today's Date:** _____

Patient Name: (print) _____

1) **What is the main reason for today's visit?** _____

2) **Yes / No** Are you having dental pain or discomfort today or recently? Rate pain (0-10) _____

Please explain: _____

3) **Yes / No** Have you had any negative experiences with dental treatment? Rate anxiety (0-10) _____

Please explain: _____

4) **Yes / No** Are there cosmetic concerns or any other dental issues you would like to discuss?

Please explain: _____

Tooth decay risk assessment for age 6 and over (Adults)

1) **Y / N** Do you notice plaque (sticky film) build-up on your teeth between brushings?
2) **Y / N** Do you snack between meals? (If yes, how often on average? x_____ / day)
3) **Y / N** Do you drink sweetened beverages, sports drinks, energy drinks, or fruit juice between meals?
4) **Y / N** Do you feel that your mouth is dry at any time of the day or night?
5) **Y / N** Do you take medications daily that list dry mouth (xerostomia) as a side effect? ☐Don't know
6) **Y / N** Do you use cannabis or other recreational drugs?
7) **Y / N** Do you have ☐Acid reflux ☐Bulimia ☐Diabetes ☐Sjogren's Syndrome ☐Head & neck radiation treatment?
8) **Y / N** Do you have exposed tooth roots, or deep pits on your teeth? ☐Don't know
9) **Y / N** Do you wear an oral appliance? (braces, partial dentures, ortho retainers, bite or snore guards, etc.)

Protective Factors

1) **Y / N** The community you live or work in has fluoride in the water. (Yes only for Healdsburg in Sonoma County)
2) **Y / N** Do you brush with standard fluoride toothpaste? (i.e. Crest®, Colgate®, etc.) How often per day? ____ x/d
4) **Y / N** Do you brush with prescription strength fluoride toothpaste? (5000ppm / 1.1% NaF) _____ x/d
5) **Y / N** Have you had fluoride varnish professionally applied in the last 6 months? (5% NaF) ☐Don't know
6) **Y / N** Do you rinse with a fluoride rinse daily? (example: ACT Rinse, 0.05% NaF)
7) **Y / N** Do you rinse with a prescription antibacterial rinse? (Chlorhexidine)

Infants & Toddlers: (age 5 and under) Tooth decay risk assessment

1) **Y / N** Mother / caregiver has had tooth decay in the past year.
2) **Y / N** Other siblings or playmates have a history of tooth decay.
3) **Y / N** Continual use of bottle containing liquid other than water or milk.
4) **Y / N** Child sleeps with bottle, or uses bottle past 24 months of age.
5) **Y / N** Frequent (> 3x/day) carbohydrate (starch or sugar) snacks, candy, soda, sugar beverage, or juice.
6) **Y / N** Saliva reducing medications. (asthma, seizure, hyperactivity, others)

Please list home dental care devices & products not listed above: (types of brushes, misc. products, etc.)

Anthony T. Fernandez, DDS, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____,
have received/reviewed a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date