WATERVIEW DENTAL CARE

5030 BUSINESS CENTER DRIVE #130 FAIRFIELD CA 94534 • (707) 864-3535

www.waterviewdentalcare.com

WELCOME TO OUR OFFICE!

We would like to share our mission statement and basic office policies with you:

MISSION STATEMENT

To provide excellence in dental care and patient service, with a focus on prevention and well-being, in a caring and compassionate manner. Through our efforts, we strive to build positive and enduring relationships with our patients and community.

If you have been referred by one of our patients you may already know our commitment to your care and well-being. We also take pride in having clear communication in all our dealings and have you involved in your treatment decisions and options.

FINANCIAL POLICY

We work with most dental insurers. Carriers vary but we'll help you with the benefits of your particular policy. We will give you a written estimate prior to treatment, send out your claim forms, and answer any questions you have. Please keep in mind you are responsible for your obligation should your insurance benefits result in less coverage than anticipated. We do ask that you take care of your co-pay at each visit. We accept checks and credit cards. We also offer Care Credit - a dental financing service that can help with payment. If you do not have Dental Insurance we offer "In-House Advantage" a discount fee plan.

CHANGING AN APPOINTMENT

We realize sudden illness or emergencies can interfere with keeping an appointment but we reserve treatment time especially for you, we ask for **48 hours** notice to change an appointment. Again, we wish to welcome you to our practice. If you value gentle, quality dental care and outstanding patient service. Dr. Dhugga and the Waterview Dental Care team are prepared to do their best in helping you achieve great oral health for life.

ABOUT YOU

Today's Date_____

_____

Name First MI Last

I prefer to be called _____

Birth date: _____ Age_____

Social Security # _____

☐ Single ☐ Married ☐ Student ☐ Divorced

Email Address_____

Home Address_____

_____

City State Zip

Home Phone# _____

Work Phone # _____

Cell Phone#_____

Occupation _____

Employer: _____

Other family members seen by us:

_____

Previous/Present Dentist: _____

Phone#_____

Last Visit Date: _____

Present Physician: _____

Phone # _____

IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU?

_____

EMERGENCY CONTACT

Name: _____

Relation: _____

Home # _____

Work # _____

Cell #_____

FINANCIAL INFORMATION

(Person Responsible for Account)

Name: _____

Address ☐ Same: If not _____

_____

Home Phone# ☐ Same: If not _____

Work Phone# _____ Ext _____

Cell Phone # _____

SPOUSE INFORMATION

His/her name: _____

Employer: _____

Work/Cell #_____

DENTAL BENEFITS COVERAGE

Primary Dental Coverage

Employee's Name: _____

Employee's SS #: _____

Employee's Birth date: _____

Relationship to Patient: _____

Insurance Co.: _____

Ins. Co. Phone #: _____

Group #: _____

Insured Employer: _____

Employer's Address: _____

Effective Date: _____

SECONDARY DENTAL COVERAGE

Employee's Name: _____

Employee's SS #: _____

Employee's Birth date: _____

Relationship to Patient: _____

Insurance Co.: _____

Ins. Co. Phone #: _____

Group #: _____

Insured Employer: _____

Employer's Address: _____

Effective Date: _____

DENTAL HISTORY

1. What brought you to the dentist today?_____

   _____

   _____

2.. Do you have any special requests before/during/after your dental appointment?

   _____

   _____

3. Are you currently in Pain? ☐ Yes ☐ No
4. Do you have any discomfort in any area of your mouth or jaw? ☐ Yes ☐ No
5. Do you any tooth sensitivity to
   ☐ Cold ☐ Hot ☐ Biting ☐ Sweets ☐ Other
6. Do your gums bleed? ☐ Yes ☐ No
7. Do you clench or grind your teeth? ☐ Yes ☐ No
8. Do you have sores, lumps or growths in your mouth ☐ Yes ☐ No
9. Do you habitually snore or suffer from Sleep Apnea ☐ Yes ☐ No
10. Do you have chronic dry mouth? ☐ Yes ☐ No
11. How long since your last?
    a) Dental Exam _____

    b) Teeth Cleaning _____
12. Are you happy with the appearance of your teeth and smile? ☐ Yes ☐ No

    If no what would you like to change?
    ☐ Whiter ☐ Straighter ☐ Other
13. Have you had adnormal bleeding associated with previous extraction surgery, or trauma ☐ Yes ☐ No
14. Past history/present cancer of mouth/lips ☐ Yes ☐ No
15. Have you had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

If so please explain _____

_____

MEDICAL HISTORY

Answers to the following questions are for our records and will be considered confidential.

1. Do you have a history of any of the following:
   - A. High blood pressure ☐ Yes ☐ No
   - B. Diabetes ☐ Yes ☐ No
   - C. Arthritis ☐ Yes ☐ No
   - D. Stomach ulcers ☐ Yes ☐ No
   - E. Thyroid disease ☐ Yes ☐ No
   - F. Asthma or hay fever ☐ Yes ☐ No
   - G. Seasonal allergies ☐ Yes ☐ No
   - H. Osteoporosis ☐ Yes ☐ No
   - I. Blood disorders/Anemia ☐ Yes ☐ No
   - J. Glaucoma ☐ Yes ☐ No
   - K. Epilepsy/Seizures ☐ Yes ☐ No
   - L. Herpes ☐ Yes ☐ No
   - M. Past History of Phen-Fen ☐ Yes ☐ No
   - N. AIDS or HIV ☐ Yes ☐ No
   - O. Tuberculoses ☐ Yes ☐ No
   - P. Stroke ☐ Yes ☐ No
2. Do You have heart disease such as:
   - A. History of heart attack ☐ Yes ☐ No
   - B. Congestive heart failure ☐ Yes ☐ No
   - C. Mitral Valve Prolapse ☐ Yes ☐ No
   - D. Heart murmur ☐ Yes ☐ No
3. Do you require antibiotics before dental treatment? ☐ Yes ☐ No
4. Do you have any implants and or Prosthesis (i.e. knee joints, elbow pins, etc.) ☐ Yes ☐ No
5. Are you taking any of the following:
   - A. Antibiotics ☐ Yes ☐ No
   - B. Anticoagulants (blood thinners) ☐ Yes ☐ No
   - C. High blood pressure medication ☐ Yes ☐ No
   - D. Cortisone (steroids) ☐ Yes ☐ No
   - E. Cholesterol ☐ Yes ☐ No
   - F. Aspirin ☐ Yes ☐ No
   - G. Insulin or oral diabetic medication ☐ Yes ☐ No
   - H. Fosamax (or any other Osteoporosis medicine) ☐ Yes ☐ No
   - I. Chemotherapy ☐ Yes ☐ No
   - J. Antiacids ☐ Yes ☐ No
   - K. Other Medications ☐ Yes ☐ No

   _____

   _____

   _____
6. Any Allergies or have you reacted adversely to:
   - A. Penicillin ☐ Yes ☐ No
   - B. Codeine ☐ Yes ☐ No
   - C. Sulfa Drugs ☐ Yes ☐ No
   - D. Latex ☐ Yes ☐ No
   - E. Ibuprofen or Motrin ☐ Yes ☐ No
   - F. Erythromycin ☐ Yes ☐ No
   - G. Tetracycline ☐ Yes ☐ No
   - H. Sedatives or sleeping pills ☐ Yes ☐ No
   - I. Vicodin ☐ Yes ☐ No
   - J. Ativan or Lorazepam ☐ Yes ☐ No
   - K. Nitrous Oxide/Anesthetics ☐ Yes ☐ No
   - L Iodine ☐ Yes ☐ No

   Please list any other drugs/materials that you are allergic to:

   _____
7. Do you smoke or chew Tobacco _____ ☐ Yes ☐ No

For Women:

8. Are you pregnant ☐ Yes ☐ No
9. Are you nursing ☐ Yes ☐ No
10. Are you taking birth control pills ☐ Yes ☐ No

Please fill out back page.

Informed Consent

1. I understand that information given today is current, correct to the best of my knowledge. I also understand this information will be kept confidential. And it is my responsibility to inform this office with any changes in my medical status.

Initials_____

2. I understand that I will be receiving a dental examination from a state licensed dental practitioner. Digital X-rays are taken as part of necessary requirements/ diagnostic tool to complete my dental examination.

Initials_____

3. I authorize the dentist to contact my physician if needed Initials_____

Changes in Treatment Plan

4. I understand that during treatment it may be necessary to change or add procedures because of conditions discovered while working on the teeth that were not found during examination and that I will be informed of any treatment changes in advance.

Initials_____

5. I give my consent to administer local anesthetic prior to dental procedure(s). I understand that the risks inherent to anesthesia and they include but are not limited to: allergic reaction, infection, bleeding, damage to nerve, or phlebitis (irritation of vein).

Initials_____

Notice of Privacy Practices

6. I Have received a copy of the Notice of Privacy Practices Sheet. Initials_____

Drugs and Medication

7. I understand that antibiotics, analgesics and other medications can cause adverse reactions. The reaction cause varies but not limited to redness, swelling, itching, vomiting, and/or anaphylactic shock.

Initials_____

8. I understand that there has been no guarantee or assurance made by any one in regards to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.

Initials_____

Authorizations for Payment

9. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities.

Initials_____

10. We kindly remind all of our patients that we require a **48 hour** notice to cancel or re-schedule any appointment otherwise $75 fee will be charged. This will help us to utilize the reserved time for other patients in need.. Initials_____

11. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Ravneet Dhugga, DDS Initials_____

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Legal Guardian Signature _____

Date

Dentist Signature _____

Date