WELCOME

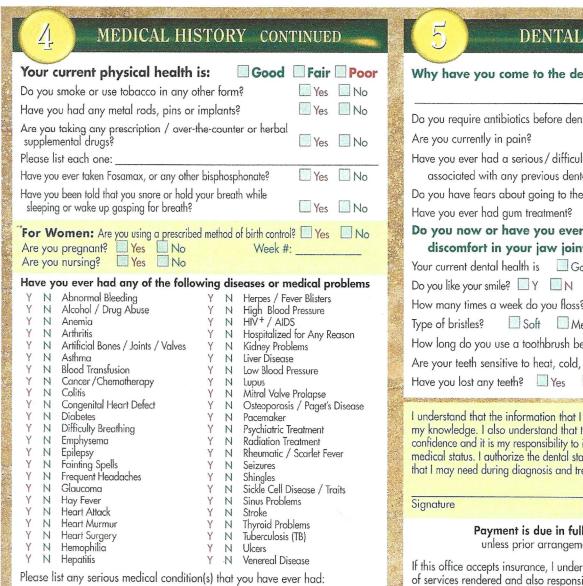
The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

The better we communicate, the better we can care for you.

ABOUT YOU
Today's Date:
E-Mail Address:
Name:
I prefer to be called: Male Female
Birthdate:/ Age: SS#:
Home Address:
Apt/Condo #
Single Married Divorced Widowed Separated
Hm #: ()
Wk #: ()
Employer:
Employer's Address:
How long there? Occupation;
Where & when are best times to reach you?
Whom may we Thank for referring you?
Other family members seen by us:
Previous / Present Dentist:
Last Visit Date:
SPOUSE INFORMATION
SPOUSE INFORMATION
His / Har Name:
His / Her Name:
Employer:
Birthdate:/ DL #:
Person Responsible for Account:
Wk #: () Ext: Hm #: ()
Billing Address:
Relationship: SS #:
Employer:DL #:

INSURANCE
Primary Insurance Dental Coverage? Yes No Insurance Co. Name:
Secondary Insurance
Dental Coverage? Yes No Insurance Co. Name: Insurance Co. Address: Insurance Co. Phone #: (
His / Her Name: Relation: Wk #: ()
City State Zip
MEDICAL HISTORY
Do you have a personal physician? Yes No Physician's Name:
Phone #: () Date of last visit:
Are you currently under the care of a physician? Yes No

CONTINUED ON BACK



Are you allergic to any of the following?

N Aspirin Y N Erythromycin Y N Tetracycline N Codeine Y N Latex Y N Other Y N Dental Anesthetics Y N Penicillin

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

Why have you come to the dentist today?				
Do you require antibiotics before dental treatment?				
Are you currently in pain?				
Have you ever had a serious / difficult problem				
associated with any previous dental work?				
Do you have fears about going to the dentist? Yes No Have you ever had gum treatment? Yes No				
Do you now or have you ever experienced pain /				
discomfort in your jaw joint (TMJ / TMD)?				
Your current dental health is Good Fair Poor				
Do you like your smile? 🗌 Y 🔲 N Do your gums ever bleed? 🔲 Y 🔃 N				
How many times a week do you floss? a day do you brush?				
Type of bristles? Soft Medium Hard				
How long do you use a toothbrush before replacing it?				
Are your teeth sensitive to heat, cold, or anything else?				
Have you lost any teeth? Yes No If yes, why?				
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 it 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.				
Signature Date				
Payment is due in full at the time of treatment unless prior arrangements have been approved.				
If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.				
Signature Date				
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.				

I verbally reviewed the medical / dental information above with the patient named herein.	Date:				
Doctor's Comments:					
MEDICAL HISTORY UPDATE					
I have read my medical history dated and confirmed that it states past and present medical conditions.					
I have read my medical history dated and confirmed that it states past and present medical conditions.	Signature Date				
I have read my medical history dated and confirmed that it states past and present medical conditions.	Signature Date				
1,100	Signature Date				

North Coast Dental 365 S. Rancho Santa Fe Rd #105 San Marcos CA 92078 (760)736-9200

"ACKNOWLEDGEMENT" of Receipt of HIPAA Notice of Privacy Practices

Patients Name (Please Print)	Patient or Guardian Signature
Authority of personal representative to	o sign for patient (check one)
_Parent _Guardian _Power of Atto	orney _Other
I tried to obtain written Acknowledgm practice's, but it could not be obtained	nent by the individual noted above of our notice of privace because:
An Emaganesia annount des Comme	shtaining adknowledgement
_ An Emergency prevented us from o	outaining acknowledgement.
· .	l us from obtaining acknowledgement.
	l us from obtaining acknowledgement.
_ A communication barrier prevented	l us from obtaining acknowledgement.
_ A communication barrier prevented _ The individual was unwilling to sig	l us from obtaining acknowledgement.
_ A communication barrier prevented _ The individual was unwilling to sig	l us from obtaining acknowledgement.

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Cancellation Policy

Dear Patients,			
If you fail to notify our office there will be a \$30.00 cance Prior to all of your appointm	llation fee. Plea	ase notify our office	24 hrs.
		reby understand th	
the cancellation policy. If I a responsibility to pay the can		iderstand that it wo	ould be my
1. The state of th			
Patient Signature	A A	Date	