NAME: **PATIENT INTAKE** **DATE:**

RESPONSIBLE PARTY INFORMATION

Responsible Party: ..... (Last Name / First Name / Initial)

Address: ..... (Street / City / State / Zip)

Home Phone: ..... Driver's Lic. No.: .....

PATIENT INFORMATION

Patient Name: ..... (Last Name / First Name / Initial)

Patient Name is pronounced: ..... Nickname: .....

Pt. Address, if different than RP: ..... (Street / City / State / Zip)

Sex: ..... M ..... F Birthdate: ..... Age: .....

Pt. Phone, if diff. than RP: ..... Hobbies: .....

School name/city: ..... Date of last dental visit: .....

Reason for today's visit: .....

Any special concerns/fears? .....

PRIMARY INSURANCE INFO

Emp. Name: .....

Emp. Addr: .....

Wk. Phone: .....

SSN: ..... Bday: .....

Plan/Union Name: .....

Employer: .....

Employer City/State: .....

Policy No.: .....

Carrier Name: .....

Carrier Add.: .....

SECONDARY INSURANCE INFO

Emp. Name: .....

Emp. Addr: .....

Wk. Phone: .....

SSN: ..... Bday: .....

Plan/Union Name: .....

Employer: .....

Employer City/State: .....

Policy No.: .....

Carrier Name: .....

Carrier Add.: .....

REFERRAL INFORMATION

Whom may we thank for referring you? .....

Address: .....

PATIENT QUESTIONNAIRE

CONFIDENTIAL

NAME _____ **BIRTHDATE** _____ **TODAY'S DATE** _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
Are you in good health?	☐	☐
Have there been any changes in your general health within the past year?	☐	☐
Date of your last physical exam: _____		
Physician's name _____		
Address _____		
Phone No. _____		
Are you now under the care of a physician?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Please explain. _____		
_____		
Are you taking any medicine(s) Including non-prescription medicine?	☐	☐
If yes, what medicine(s) are you taking? _____		

	YES	NO
Have you had any abnormal bleeding?	☐	☐
Do you bruise easily?	☐	☐
Have you ever required a blood transfusion?	☐	☐
Have you had a recent weight loss?	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐
Have you taken Fosamax? (Bisphosphonate)	☐	☐

MEDICAL HISTORY CONTINUED...

Are you allergic to or have you had reactions to:	YES	NO
Local anesthetics like novocaine?	☐	☐
Penicillin or other antibiotics?	☐	☐
Barbiturates, sedatives or sleeping pills?	☐	☐
Aspirin?	☐	☐
Latex or Other?	☐	☐
Have you ever taken Bisphosphnates?	☐	☐
Do you have or have you ever had the following:	☐	☐
Rheumatic heart disease or rheumatic fever?	☐	☐
Scarlet fever?	☐	☐
Heart defect or heart murmur?	☐	☐
Heart trouble, heart attack, or angina?	☐	☐
A. Do you have pain in your chest upon exertion?	☐	☐
B. Are you ever short of breath after mild exercise?	☐	☐
C. Do your ankles swell?	☐	☐
D. Do you get short of breath when you lie down?	☐	☐
E. Do you require extra pillows when you sleep?	☐	☐
Pacemaker?	☐	☐
Heart surgery?	☐	☐
High blood pressure?	☐	☐
Low blood pressure?	☐	☐
Hepatitis, jaundice or liver disease?	☐	☐

	YES	NO
Stroke?	☐	☐
Sinus trouble?	☐	☐
Lung or breathing problems?	☐	☐
Asthma or hay fever?	☐	☐
Hives or skin rash?	☐	☐
Fainting spells or seizures?	☐	☐
Diabetes?	☐	☐
AIDS or HIV infection?	☐	☐
Thyroid problems?	☐	☐
Allergies?	☐	☐
Arthritis or rheumatism?	☐	☐
Joint replacement or implant?	☐	☐
Stomach ulcer?	☐	☐
Kidney trouble?	☐	☐
Tuberculosis?	☐	☐
Persistent cough?	☐	☐
Cough that produces blood?	☐	☐
Cancer?	☐	☐
Sexually transmitted disease?	☐	☐
Epilepsy?	☐	☐
Anemia?	☐	☐
Leukemia?	☐	☐
Glaucoma?	☐	☐

Signature _____ Date _____

FINANCIAL POLICY

We are please you have chosen Dr. Margaret Bobinski, D.D.S. for your dental health care. To continue a happy, long lasting, relationship, we ask all of our patients to read and sign our financial policy, so you will know what you can expect from us as well as what is expected of you:

Photo ID and Insurance Card/Cards (in the case of dual coverage) will need to be copied by office staff.

Non-Insurance Patients:
Patients without insurance are expected to pay for all services rendered. For your convenience we accept cash, personal checks, money orders and credit card payments at the time of service. For information on these services, please ask our office staff. For crowns, bridges, partials and dentures: a laboratory retainer fee of half of the charged fee is due on the day impressions are taken unless prior arrangements have been approved.

Insurance:
As a courtesy to our patients with dental insurance, we can submit insurance claims to your carrier upon prior notification and certification of your coverage. At the time of service, patients are responsible for all deductibles and patient portions. Anticipation of benefits expected are clearly ***estimates***. The actual balance due after the insurance payment is the responsibility of those seeking treatment. We would like to emphasize that our relationship is with you and NOT your insurance company. Please understand that any dental procedures or services not covered by your insurance or if you have met your contract limitations, you will be responsible for the balance owed to our office.

A service charge of 1-1/2% per month (18% per annum) (but in no event more than the maximum rate permissible within under state law) will be charged on the unpaid balance on all accounts not paid with 60 days of treatment date.

There is a $30.00 charge for all returned checks.

PLEASE BE ADVISED THERE IS A CHARGE OF $25.00 FOR BROKEN APPOINTMENT WITHOUT A MINIMUM OF 24 HOURS ADVANCE NOTICE.

I have read the information above and I will abide by the financial policy of Dr. Bobinski.

Name of Patient _____

_____

Signature (Parent or Guardian) Date

MARGARET BOBINSKI DDS
7410 GREENHAVEN DRIVE , SUITE 107
SACRAMENTO , CA 95831

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____
Patient or Guardian Name Date

_____ _____
Witness Date