Ramona Rivera DDS

9833 Fair Oaks Blvd. Suite E • Fair Oaks, CA 95628 (916)967-2217

Welcome to our Practice

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ________________________ **Best time to call:** ____________

Phone: ________ Home ________ Mobile ________ Work ____ Ext ________ Fax ________ Other

Address: ____________________ Address 1 ____________________ Address 2

____________________ City ____ State _____-____ Zip Code

Whom may we thank for referring you to our practice?

____

In an emergency who should be notified? Please enter Name and Phone number below:

Emergency Contact:

____

____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ____________________ **Phone:** ____________

Employer Address: ____________________ Address 1 ____________________ Address 2

____________________ City ____ State _____-____ Zip Code

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ___ ______________
Last First MI Preferred Name

Title: ________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ________ **SS#:** ___-__-____ **DL#:** ______________

Email Address: ______________ **Best time to call:** ________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: ______________ ______________ ___
Last First MI

Insured's Birth Date: ________ **ID #:** ________ **Group #:** ________

Insured's Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Insured's Employer Name: ______________

Employer Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________

Insurance Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Insurance Company Phone Number:

____

____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

____

____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: __________

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Medical History

Patient Name: ____________ ____________ ____ ____________

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med
- ☐ Allergy-Acetominophen
- ☐ Allergy-Amoxicillin
- ☐ Allergy-Codeine
- ☐ Allergy-Erythromycin
- ☐ Allergy-Keflex
- ☐ Allergy-Latex
- ☐ Allergy-Nifedipine
- ☐ Allergy-Other
- ☐ Allergy-Penicillin
- ☐ Allergy-Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ HIV
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tumors
- ☐ Ulcers

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

____

____

____

____

Allergies not listed:

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

____

____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy and Phone Number:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ____________ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ Prev. Visit: ____________ Email Address: ____________

Phone: ____________ ____________ ____________ ______ Best time to call: ____________
Home Mobile Work Ext

Address: ____________ ____________
Address 1 Address 2

____________ ______ ______-______
City State Zip Code

Response Date: ____________