PLAZA DENTAL GROUP

4205 San Felipe Road, Suite 200, San Jose, CA 95135 (408) 270-4333

Chart #:_____
FOR OFFICE UUSE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birthdate: _____ Driver's License #_____ State_____

Phone (Home): (____)_____ (Cell) (_____)_____ (Work): (_____)_____ Ext:_____

Home Street Address: _____
Street *Apartment #*

City, State Zip _____ _____ _____ Email_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please read this carefully and circle Y for Yes and N for No:

AIDS/HIV	Y	N	Heart Murmur, Functional	Y	N	Stomach Problems	Y	N	Aspirin Allergy	Y	N
Anemia	Y	N	Hepatitis	Y	N	Stroke	Y	N	Codeine Allergy	Y	N
Artificial Joints	Y	N	High Blood Pressure	Y	N	Taking Blood Thinner	Y	N	Latex Allergy	Y	N
Asthma	Y	N	Jaundice	Y	N	Thyroid Disorder	Y	N	Penicillin Allergy	Y	N
Auto Immune Disorder	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N	Other Allergies_____		
Cancer_____	Y	N	Liver Disease	Y	N	Tumors/Cysts	Y	N	OTHER:		
Diabetes	Y	N	Mental Disorders	Y	N	Ulcers	Y	N	☐ _____		
Epilepsy	Y	N	Pacemaker	Y	N	Venereal Disease	Y	N	☐ _____		
Excessive Bleeding	Y	N	Pregnant	Y	N	Other	Y	N			
Fainting	Y	N	Due Date: _____			Explain:_____					
Head Injuries	Y	N	Respiratory Problems	Y	N	**ALLERGIES:**					
Head-Neck Radiation	Y	N	Rheumatic Fever	Y	N	Anesthetic Allergy	Y	N			
Heart Disease	Y	N	Sinus Problems	Y	N	_____					

Official Use Only
☐ PreMedicate ☐ No Epinephrine
Dr/RDH_____
Date_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone:_____
- Whom may we contact in the event of a medical emergency? Name_____
  Relationship to patient_____ Day Phone_____ Eve Phone_____
- Have you ever taken the medication Fen-Phen or Redux? ☐ Yes ☐ No
- What medications, vitamins, or herbal remedies are you taking at this time? _____

_____

- Do your gums bleed when you floss or brush? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke daily? _____
- Have you ever used recreational drugs? ☐ Yes ☐ No If yes, explain_____
- Do you have frequent headaches? ☐ Yes ☐ No Do you clench or grind your teeth? ☐ Yes ☐ No
- Does your jaw ever get "stuck," locked," or "go out"? ☐ Yes ☐ No
- What changes would you like to make to the appearance of your teeth? _____

_____

Have you ever had an unfavorable reaction to Nitrous Oxide? ☐ Yes ☐ No If yes, explain_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X Signature of patient, parent or guardian_____ Date:_____

PERMISSION TO DENTISTS/HYGIENISTS -- I give my consent to use local anesthetic or relaxants for completing necessary dental treatment.

X Signature of patient, parent or guardian_____ Date:_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Internet Search Please specify what internet source you used to locate us. _____

☐ Yellow Pages Please specify_____ ☐ Evergreen Yellow Pages ☐ Times Newspaper ☐ Other_____

Name of person or office referring you to our practice:_____

Patient Employment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Employer Phone: _____

Spouse or Guardian Information

The following is for: ☐ the patient's spouse ☐ parent ☐ guardian

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Home Street Address: _____

City, State, Zip: _____

Employer Name: _____ Occupation: _____

Street, City, State, Zip _____

Consent for Services

As a condition of your treatment by this office, 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. The practice depends upon reimbursement from the patients for the costs incurred in their care. As a condition of your treatment by this office, services are to be paid when rendered, or definite financial arrangements must be made and approved by Plaza Dental Group prior to commencement of treatment.

Patients who carry dental insurance understand that all dental services furnished 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 such 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.

Plaza Dental Group reserves the right to check credit on the above named patient, spouse and/or responsible party, and signature below authorizes Plaza Dental Group to make credit inquiry of the patient, spouse, or responsible parties. A service charge of 1.5% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, by the Doctor or Hygienist, I agree to pay therefore the reasonable value of said services to Plaza Dental Group, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed. 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.

REGARDING MISSED OR CANCELED APPOINTMENTS: Once I make an appointment, the time will be reserved for me. If I miss or cancel a dental appointment without 48 hours advance notice, I agree to pay $25 for each one-half hour of appointment time reserved. This policy is needed to prevent delays of my treatment as well as other patients. I realize that the delay of a missed or cancelled appointment may jeopardize my dental health.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X Signature of patient, parent or guardian_____ Date: _____ Relationship to Patient: _____

X Signature of guarantor of payment/responsible party_____ Date: _____ Relationship to Patient: _____