Prosthodontics Implant Dentistry of Laguna Hills
25261 Paseo De Valencia Ste 2 Laguna Hills CA 92637
(949) 951-7988

Chart#:_____

Patient Information

Patient Name: _____ Date: _____

☐ male ☐ female ☐ married ☐ single ☐ child ☐ other

Social Security #: _____ Birthdate: _____

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

Cell Phone#: _____ Email: _____

Address: _____ Apt#: _____

_____
City State Zip Code

Health Information

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

Have you ever had any of the following? Please check those that apply:

☐AIDS	☐Excessive Bleeding	☐Liver Disease	☐Tuberculosis
☐Allergies _____	☐Fainting	☐Mental Disorder	☐Tumors
☐Anemia	☐Glaucoma	☐Pacemaker	☐Ulcers
☐Arthritis	☐Growths	☐Pregnancy	☐Venereal Disease
☐Artifical Joints	☐Hay Fever	Due Date:_____	☐Codeine Allergy
☐Asthma	☐Head Injuries	☐Radiation Tx	☐Penicillin Allergy
☐Blood Disease	☐Heart Disease	☐Respiratory Issues	☐Other:
☐Cancer	☐Heart Murmur	☐Rheumatism	_____
☐Diabetes	☐Hepatitis	☐Sinus Problems	_____
☐Dizziness	☐High Blood Pressure	☐Stomach Problems	
☐Epilepsy	☐Jaundice	☐Stroke	

Have you ever had any complications following dental treatment? ☐YES ☐ NO

If yes, please explain: _____

Are you currently taking medication (s)? ☐ YES ☐ NO

If yes, please explain: _____

Are you now under the care of a physician? ☐ YES ☐ NO

If yes, please explain: _____

Name of your Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ YES ☐ NO

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any chance in my health, I will inform the doctor's at the next appointment.

_____ Date: _____

Signature of patient, parent, or guardian

Referral Information

Whom may we thank for referring you to our office? ☐Patient or friend ☐Relative ☐Dental Office ☐Internet

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

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ male ☐ female ☐ married ☐ single ☐ child ☐ other

Social Security #: _____ Birth Date: _____

Cell Phone number: _____ Work: _____ Ext: _____

Address: _____ Apt: _____

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employment Name : _____ Occupation _____

Address: _____ Apt: _____

_____

City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the party of each patient must be determined before treatment.

All emergency dental services, or dental services performed without previous financial arrangement, must be paid for in cash at the time services are performed.

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 patients 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 paid by an insurance company.

A service charge of 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 the fee estimate listed for this denial 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services were 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 unless objected to, by me, in writing, within the time for paymemt thereof. 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 fees if instiluted hereunder

I grant my permission to you or your assignee 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.

_____ Date: _____ Relationship to patient _____

Signature of patient, parent

_____ Date: _____ Relationship to patient _____

Signature of guarantor of payment / responsible party

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Prosthodontics & Implant Dentistry

1. Cancelation / No Show Policy for Dental Appointment

We understand that there are times when you must miss an appointment due to emergnencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation / No Show Policy of Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a eighty-five ($85) fee; that is will not be covered by your insurance company.

4. Account Balances

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak Mayra Juarez or Naz Dion our front desk patient and treatment coordinators with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangments prior to future appoinments being made.

_____
Patient Printed Name

_____ _____
Patient Signature Patient/Guardian Date