Parc Center Dental Group

parccenterdental.com
77-564B Country Club Drive | Ste 350 • Palm Desert, CA 92211
parccenterdental@yahoo.com
(760)772-7082

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ___ (MI) _____ (Preferred Name)

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

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

What is your immediate concern?

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

We are dedicated to serving your dental needs with the best professional advice, care and service. Please understand that payment of your bill is part of your treatment. We sincerely hope your visit will be a pleasant and rewarding experience.

REGARDING PAYMENT:

Full payment is due at the time services are rendered unless prior arrangements have been made with the financial coordinator Dennise. We accept all credit cards, checks, cash and Care Credit.

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance benefit company. It is your responsibility to know your insurance policy rules limitations and benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf.

MISSED APPOINTMENTS:

Appointment times are reserved exclusively for scheduled patients only. We require 24 hour notice for canceling and rescheduling appointments. If any appointment is cancelled same day, patients will be charged a $75 broken appointment fee.

CANCELLATION POLICY:

Hygiene appointments (Cleanings) must be confirmed by the day prior to the appointment. If appointments are not confirmed, the appointment will be canceled.

Our office tries its best to accommodate all patients. These policies are in place due to long cancellation lists.

I understand and accept the financial and dental insurance policies listed above.

☐ ***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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Confidential Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Medical Conditions

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.

- ☐ A-Fib
- ☐ Anemia
- ☐ Aneurysm
- ☐ Arthritis/ Joint Stiffness
- ☐ Artificial Heart Valves
- ☐ Bactrim,
- ☐ Bladder Disease
- ☐ Blood Disease
- ☐ Blurred Vision
- ☐ Bruises Easily
- ☐ Canker/ Cold Sore
- ☐ Chest Pain (Angina)
- ☐ Cosmetic Surgery
- ☐ Crohn' Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Headache
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Kidney
- ☐ Levaquin/Levofloxacin
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Ondansetron
- ☐ Organ Transplant
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Parkinson
- ☐ Percocet
- ☐ Persistant Cough
- ☐ Recent Significant Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Ringing in Ears
- ☐ Seizure
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disease
- ☐ Stent in heart
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ TMJ
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vancomycin
- ☐ Venereal Disease (STD)
- ☐ Zithromax/Azithromycin

Allergies

Are you allergic to or have you had a reaction to any of the following?

- ☐ Aspirin
- ☐ Valium/ Sedatives
- ☐ Codeine/ Opioids
- ☐ Latex
- ☐ Sulfa
- ☐ Metal
- ☐ Penicillin
- ☐ Food/ Fruit
- ☐ Nitrous Oxide
- ☐ Local Anesthetic/ Novacaine
- ☐ Others

If you marked YES to any allergies above, Pleas explain type of allergic reaction.

- ☐ Blocked Airways/ Trouble Breathing
- ☐ Nausea/ Vomiting
- ☐ Rapid Weak Pulse
- ☐ Dropping Blood Pressure
- ☐ Skin Rash
- ☐ Lip Swelling
- ☐ Others

Please respond YES or NO to the following

Tumors or Cancer * ◯ Yes ◯ No

If YES Please indicate Type and Treatment and Date of Treatment (Surgery, Radiotherapy, Chemotherapy, Others)

_____

_____

Heart Disease/ Defect/ Attack * ◯ Yes ◯ No

If YES Please indicate Type and Treatment

_____

_____

Pacemaker/ Watchman/ Heart Valve Placement * ◯ Yes ◯ No

Please list date implanted

_____

_____

Diabetes * ◯ Yes ◯ No

Please indicate Type and if you inject Insulin- Is you blood sugar under control?

_____

_____

Asthma: Do you use an inhaler? * ◯ Yes ◯ No

Psychiatric Care * ◯ Yes ◯ No

If YES please list reason and diagnosis

_____

_____

Artificial Joint * ◯ Yes ◯ No

Please list Date of Surgery and Type

_____

_____

Other Surgeries: Please list Dates and Procedure

_____

_____

_____

Hospitalization: Date and Reason

_____

_____

_____

AIDS/ HIV * ◯ Yes ◯ No

Detectable or Non Detectable _____

Thyroid Disease ◯ Yes ◯ No

Name Condition

Has there been any change in your health within the last year? * ◯ Yes ◯ No

If YES please explain.

Are you being treated by a physician now? * ◯ Yes ◯ No

If YES please explain.

Date of last medical exam and reason?

Do you have or have you had any other disease or medical condition not listed on this form? If YES please explain.

Have you ever been premedicated for dental treatment? * ◯ Yes ◯ No

If YES, please explain reason and list type of medicine

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:

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

_____

_____

_____

_____

Have you ever taken any of the following:

☐ Recreational Drugs

☐ Opiods (Norco, Vicodin, Percocet, Percodan, etc...)

☐ Tobacco in any form

☐ Others

If marked YES to the above question, Please explain reason:

_____

_____

Have you tested positive for Covid-19? Please list date of last positive test. _____

Have you had any lasting/ on-going symptoms or effects as a result of Covid-19? If YEs, please list below.

_____

_____

_____

The following question are for women only:

Are or could you be pregnant? ◯ Yes ◯ No

If YES to above question: please state how many months _____

Are you nursing? ◯ Yes ◯ No

Are you taking birth control? ◯ Yes ◯ No

_____

Dental History

Reason for today's visit: _____

Former Dentist Name and contact information.

_____

_____

Date of last Dental Visit: Please list as (Month/Year) _____

Please check if you have any of the following:

☐ Bad Breath

☐ Periodontal Treatment (Gum Treatment)

☐ Fingernail Biting

☐ Grinding or Clenching Teeth

☐ Clicking or Popping Jaw

☐ Bleeding Gum

☐ Blister on lips or Mouth

☐ Sensitive to Cold/ Hot/ Sweets

☐ Dry Mouth

☐ Jaw Pain/ Tenderness

☐ Pain Around the Ear

How often do you floss? _____

How often do you brush? _____

_____

☐ ***The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my Physician**

Whom would you like us to contact in the case of an emergency? Please list name, and phone number.

_____

_____

Relationship to patient?

_____

_____

☐ ***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.**

☐ **I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accuratley. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.**

Medical Update:

☐ **I have reviewed my Health History and confirm that it accurately states past and present conditions.**

Dentist/ Provider Signature:

Signature _____ **Date** _____

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

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Signature _____ **Date** _____

Please list any change to health history or medication, please explain.

_____

_____

_____

Dentist Signature:

Signature _____ **Date** _____