1600 Webster Street Ste. C, San Francisco CA 94115
Tel: (415) 500-2116

New Patient Form

Patient Information:

First Name______________________________Last Name______________________________
Preferred Name__________________Birthday__________________Social Security#__________
Address____
City____________________________________State__________Zip________________
Phone______________________Email____
Emergency Contact?________________________________Phone________________________

Insurance Information:

Insured Person's Name____________________________________Date of Birth______________
Member ID#____________________________Relationship to Patient________________________
Insurance Name______________________________________Insurance Phone#________________
City________________________State__________Zip__________Policy/Group#__________________
Insured Person's Employer____
Employer Phone__________________________

How did you hear about our office? ____

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between Doctor and Patient and /or Guardian to be necessary or advisable, including the use of local and/or general anesthesia and other medications as indicated. I am responsible for payment of services rendered.

Patient Signature____**Date**______________________

[Medical History]

General Information

Yes No Is your health good?____
Yes No Has there been a change within 3 years? If yes, please explain__________________
____
Date of your last dental Exam & X-rays?____
Have you had any complications with your previous dental treatment? If yes, please explain_____
____
Is there anything that you want us to do to make you more comfortable? If yes, please tell us____
____

Medical History (continued)

Have you experienced any of the following?

Yes	No	Chest Pain	Yes	No	Dizziness
Yes	No	Swollen Ankles	Yes	No	Headaches
Yes	No	Shortness of breath	Yes	No	Ringing in ears
Yes	No	Joint pain, TMJ syndrome	Yes	No	Fainting spells
Yes	No	Persistent coughs	Yes	No	Seizures
Yes	No	Bleeding problems, Bruising	Yes	No	Excessive thirst
Yes	No	Sinus problems	Yes	No	Dry mouth
Yes	No	Frequent vomiting			

Do you have or had any of the following?

Yes	No	Heart Disease	Yes	No	VD (syphilis,gonorrhea)
Yes	No	Heart Attacks, heart defects	Yes	No	AIDS / HIV+
Yes	No	Heart Murmurs	Yes	No	Eye diseases
Yes	No	Prosthetic heart valve	Yes	No	Blood disorder
Yes	No	Pacemaker	Yes	No	Anemia
Yes	No	Rheumatic fever	Yes	No	Skin Diseases
Yes	No	Stroke, hardening of arteries	Yes	No	Herpes
Yes	No	High blood pressure	Yes	No	Blisters
Yes	No	Diabetes	Yes	No	Stomach problems, Ulcers
Yes	No	Kidney, Bladder diseases	Yes	No	Thyroid, Adrenal diseases
Yes	No	TB, Emphysema/other lung diseases	Yes	No	Tumor/Cancer
Yes	No	Allergies to ____________________	Yes	No	Hepatitis A/B/liver diseases
Yes	No	Psychiatric care	Yes	No	Radiation Treatment
Yes	No	Blood transfusion	Yes	No	Chemotherapy
Yes	No	Artificial joint or pins			

Yes No Do you have or had any other disease or medical problems that are not listed on this form?

If yes please explain____

Additional Medical Questions:

Yes No Recreational drugs. If yes which types?____________________

Yes No Drugs, Medications. If yes which types?____________________

Yes No Tobacco in any form. If yes how often?____________________

Yes No Alcohol. If yes how often?____________________

Yes No Are you/could you be pregnant? If yes how many months?____________________

Yes No Are you taking birth control pills?____________________

Smile design

Yes No Are you satisfied with the appearance of your teeth?

Yes No Would you like whiter teeth?

Yes No Have you had orthodontic (braces) treatment?

Yes No Would you like straighter teeth?

To the best of my knowledge, I have answered and completed all of the above information fully and accurately. I will inform my dentist of any changes in my health/medications/information.

Patient Signature ________________________________ **Date**____________

Welcome to Innovative Dental!

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Our Policies

Patient with Third Party Indemnity Insurance, (Individual or Employer Plans):
We bill the insurance company at a usual and a customary fee. You may have contractual obligations between yourself and your plan. It is the patient's responsibility to know what your insurance benefits are and if prior authorization is necessary before services are rendered. Billing your insurance carrier is a courtesy service. We assume NO liability for insurance/eligibility issues, which may deny payment. Your insurance company may hold you responsible for payment of our services at the fee, which we bill. The patient portion, if it applies, will be collected at the time of treatment since we normally do not bill. A bill will only be sent if a service payment is missed or prior arrangements are made. Please review your insurance claim information for your financial responsibilities.

Payment Options:
If paying cash, fees are according to our cash fee schedule and are required to be paid at the time of service unless a prior financial arrangement is made. Major credit cards are accepted. Individuals can also apply for an alternative credit plan with payment options. Returned checks will be charged the fee the bank applies to us.

Collection of Fees:
Patients may need to contact their carrier to be certain Innovative Dental receives payment within 30 days services. Patients may be held financially responsible if payment is not received in a reasonable time or if payment for treatment is denied for any reason. The balance will be due immediately.

Overdue Accounts:
Accounts are considered delinquent when charges become 60 days past due. If an account is sent to collection additional collection fee will be charged to the patient's account. Any account balance which is not on the payment plan and which is over 60 days old will have a finance charge of 1.5% per month (18% APR) added.

Cancellation Fee:
All cancellations and reschedules should be made 48 hours prior of the scheduled appointment, cancellations within 48 hours are consider as missed appointment. A three days cancellation notice is required for all major appointments that are scheduled longer than 2 hours, a fee of $100 will apply if a major appointment is cancelled or rescheduled within three business days. A $50 fee will be charged for the first missed appointment, $75 for second missed, $100 for third missed appointments, patient will be dismissed after the third missed appointment. Cancellation notice must be received during our normal business hours, this fee is not covered by insurance.

By signing below, I understand and agree to the above policies and acknowledge the receipt of **Notice of Privacy Practices** (next 2 pages).

Signature:____________________________________ Date:____________________

Thank you for choosing Innovative Dental for your dental needs. We look forward to having you as a patient and helping you achieve positive health!