PATIENT INFORMATION

Welcome to Peninsula Dental Care, PLLC.

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ______________________ Preferred name ______________________

Date of Birth ______________________ Social Security number: ______________________

If minor, parents' names ______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Minor

Mailing address ______________________ City ______________ State ________ Zip ____________

Home phone ______________ Work phone ______________ Cell phone ______________

E-Mail Address ______________________

Employer ______________________ Occupation ______________________

Emergency Contact ______________________ Phone Number: ______________________

How did you hear about our office? ❑ I am a previous patient of Dr. Pham/Dr. Becker ❑ Website ❑ Facebook

❑ Newspaper ❑ Insurance Website ❑ Dental Flyer ❑ Google ❑ Other: ________________

❑ Friend - If you were referred by a friend, whom may we thank? ______________________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Bones
- ❑ Artificial Heart
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Bisphosphonates
- ❑ Blood Transfusion
- ❑ Cancer
  Type: ________
- ❑ Congenital Heart Defect
- ❑ Diabetes
  Type: ________
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis
  Type: ________
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Metals
- ❑ Tetracycline
- ❑ Other: ______________________

Please list your medications or provide us with a list to copy:

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Women:

- ❑ Are you pregnant or may be pregnant?
  Estimated # of weeks: ________________
- ❑ Are you nursing?
- ❑ Are you taking birth control?

Name & Phone Number of your physician: ______________________

Do you have any disease, condition, or problem not listed above? ______________________

Do you **Premed** with antibiotics before dental procedures?________ Are you on any **blood thinners** or anticoagulants? __________

Patient (or Parent/Guardian) Signature: ______________________ **Date**: ______________

DENTAL INSURANCE INFORMATION: ❑ **Not covered by dental insurance**

Subscriber ______________________ Employer______________________
Insurance company ______________________ Group number ______________________
Subscriber's ID#______________________ Date of Birth______________________

Are you covered by a secondary dental insurance? ❑ Yes ❑ No
Subscriber ______________________ Employer______________________
Insurance company ______________________ Group number ______________________
Subscriber's ID#______________________ Date of Birth______________________

Guarantor Information (Person responsible for account or insurance)

Guarantor's Name ______________________ Social Security Number: ______________________
Employer Name ______________________Address ______________________
City ______________________ State______ Date of Birth ______________ Phone# ______________________

Payment for services is due at the time services are rendered, unless our staff has approved payment arrangements in advance. We accept cash, checks, Care Credit, CitiHealth, Discover, MasterCard or Visa. On delinquent accounts, finance charges and any billing, accounting, collection and/or legal fees will be added to the past due account. You are responsible for these charges.

We will gladly discuss your proposed treatment and answer any questions related to your insurance, provided you furnish us with your dental plan information. You must realize however, that:

a. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. You are responsible for keeping us updated on any changes to your policy.
b. Our fees generally fall within the acceptable range of most insurance companies, and therefore are usually covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage of "Usual and Customary Rates" or "UCR." This statement does not apply to companies that reimburse based on an arbitrary "Schedule of Fees," that bears no relationship to the current standard of cost of care in this geographic area.
c. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that will not cover (e.g. implants, tooth whitening, bite guards).

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.
A 1.5% monthly service charge will be added to any account balance that is remaining after 30 days. Past due accounts over 90 days will be turned over for collection procedures. You are responsible for all collection and/or legal fees.

(**Initial Here**) ____________ Peninsula Dental Care maintains a 2 BUSINESS DAY cancellation policy. If for any reason you are unable to make your scheduled appointment, please notify the office no less than 2 BUSINESS DAYS prior to the appointment. If you fail to show for your scheduled appointment or cancel within the 2 BUSINESS DAYS, a fee of $50 will be assessed for every 30 minutes scheduled.

HIPAA and Privacy Practices:
Peninsula Dental Care reserves the right to research information regarding any prescription drug use through the Virginia Prescription Drug Monitoring Program (PDMP).

(**Initial Here**) ____________ Our office is committed to maintaining your medical privacy. Accordingly, we have published a "Notice of Privacy Practices" that delineates our policy with regards to maintaining your personal information. By initialing here, you acknowledge that you have read our published policy. A printed copy of our policy can be provided to you. (**Copy Desired: YES / NO**)

(**Initial Here**) ____________ I give permission to Peninsula Dental Care to use my photographs for education and promotional (Facebook/Website) purposes. I release my right for any compensation in connection with the use of these photographs.

Signature of Patient (or Parent/Guardian) ______________________________ Date ______________