DSF

Dentistry of San Francisco

Patient Profile

First Name_____ Last Name_____ Pref. Name _____

Date of Birth_____ Age_____ Soc. Sec. # _____

Gender_____ Marital Status_____ Previous Dentist _____

Home Address _____

City_____ State_____ Zip Code _____

Home #_____ Cell # _____

Work #_____ Ext_____ Occupation_____

Email_____ Emergency Contact _____

Phone #_____ Relationship to Patient _____

Appointment Preference

How do you prefer to be reached: ☐ Home # ☐ Cell # ☐ Text to Cell # ☐ Work # ☐ Email

My preferred appointment times are: ☐ Morning ☐ Afternoons ☐ Evenings ☐ No Preference

Referral Profile

How did you hear about our office? _____

Insurance Profile

Name of Insured_____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec #_____ Date of Birth _____

Employer_____ Insurance Company _____

Insurance ID #_____ Group # _____

500 Sutter St., Suite 600
San Francisco, CA 94102
415.986.5323

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Medical History

Patient Name _____ Date of Birth _____

Name of Physician _____ Date Last Physical Exam _____

Have you ever been hospitalized or had a major injury? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have taken, Phen-Fed or Redux? ◯ Yes ◯ No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes, please explain: _____

Do you use tobacco? ◯ Yes ◯ No If yes, please explain: _____

Are you allergic to any of the following?

◯ Aspirin, Motrin, Tylenol ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex

◯ Other: If yes, please explain _____

Women, are you:

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Do you have or have had any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	COPD / Lung Disease	◯ Yes ◯ No	Heart Disease	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Depression	◯ Yes ◯ No	Hepatitis (Type_____)	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Digestive Disorders	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Angina/Chest Pains	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Epilepsy / Seizures	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Bleeding Problems	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Gastric Reflux (GERD)	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores / Fever Blisters	◯ Yes ◯ No	Heart Attack / Failure	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Cortisone Medicine	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Weight Gain/Loss	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Please List all medications, supplements, and vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

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Dental History

What is your immediate concern? _____

Previous Dentist_____How Long Were You a Patient_____Months / Years

Routinely Saw My Dentist Every: ◯ 3 months ◯ 4 months ◯ 6 months ◯ 12 months ◯ Not Routinely

Please check off all the things that would keep you from pursuing your dental treatment:

◯ Cost ◯ Fear ◯ Lack of Time ◯ Lack of Importance ◯ Other _____

Please answer the following questions so that we may get to know you better:

PERSONAL DENTAL HISTORY

Have you ever had an unfavorable dental experience?	◯ Yes ◯ No
Have you ever had complications from past dental treatment?	◯ Yes ◯ No
Have you ever had trouble getting numb in the past?	◯ Yes ◯ No

SMILE CARE

Are you self-conscious about the appearance of your teeth?	◯ Yes ◯ No
Are you happy with the color of your teeth?	◯ Yes ◯ No
Have you ever had orthodontics in the past?	◯ Yes ◯ No
Do you like the shape and position of your teeth?	◯ Yes ◯ No
Do you wear dentures or partials?	◯ Yes ◯ No

BITE & JAW JOINT AND TOOTH STRUCTURE

Have your teeth become shorter, thin, and/or worn in recent years?	◯ Yes ◯ No
Do you have any problems with your jaw joint? (Ex-Clicking, Pain, Etc.)	◯ Yes ◯ No
Do you or have you ever worn a bite appliance?	◯ Yes ◯ No
Do you clench or grind your teeth?	◯ Yes ◯ No
Do you get frequent headaches?	◯ Yes ◯ No
Have you ever had a toothache, cracked filling, or broken tooth?	◯ Yes ◯ No
Are any teeth sensitive to hot, cold, biting, or sweets?	◯ Yes ◯ No
Do you avoid brushing any part of your mouth?	◯ Yes ◯ No
Do you feel any pain from any of your teeth?	◯ Yes ◯ No
Have you ever had a tooth extracted?	◯ Yes ◯ No

GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?	◯ Yes ◯ No
Is there anyone in your family with a history of periodontal disease?	◯ Yes ◯ No
Have you ever experienced gum recession?	◯ Yes ◯ No
Do your gums bleed when brushing, flossing, or eating?	◯ Yes ◯ No
Have you ever noticed an unpleasant taste or odor in your mouth?	◯ Yes ◯ No
Do you have any sores or lumps in or near your mouth?	◯ Yes ◯ No

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HIPAA Authorization

I, (Patient Name or Legal Guardian)_____, authorize the practice of Dr. Joseph and its staff to provide medical treatment and to release information related to patient treatment, payment, or health care operations.

I further acknowledge receipt of this practice's Notice of Privacy Practices and rights to review the Provider's Privacy Requirements.

Signature of Patient or Legal Guardian_____ Date _____

Office Policies

At our office we believe in devoting our entire focus towards each patient. Please understand for this to happen we specifically reserve time in the schedule for your treatment needs. Due to the demand for these appointment slots, the following office policies may apply:

THERE WILL BE A $75 FEE CHARGED TO YOUR ACCOUNT IF YOU DO NOT COME TO YOUR HYGIENE APPOINTMENT AND/OR DO NOT CALL THE OFFICE WITHIN A 24-HOUR PERIOD TO RESCHEDULE.

IF YOU HAVE RESERVED TIME WITH THE DOCTOR, THE FEE WILL BE ASSESSED BASED ON YOUR TREATMENT PLAN AND THE LENGTH OF THE APPOINTED TIME MISSED.

WE WILL CERTAINLY TRY TO ACCOMMODATE AS BEST AS WE CAN DURING ALL OF THESE CIRCUMSTANCES.

Our staff wants to be available for your needs and the needs of all our patients. We appreciate your understanding of these office policies to help accommodate everyone and thank you for working together with us.

We greatly appreciate and thank you for being a valued patient.

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Our Financial Policy

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

You are responsible for payment of all services rendered. Payment in full is required at the time of service. We may accept assignment of your insurance benefits, but please understand your insurance policy is a contract between you and your insurance company. We have no influence in the terms agreed upon between you and your insurance company. We are happy to submit your insurance claim but we will need all of your insurance information. Failure to do so prohibits any claim submission and the entire balance will be due immediately. If a portion of your treatment will be covered by your insurance, we require your co-pay portion to be paid at the time of service. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. The balance is your responsibility whether your insurance company pays or not. Please be aware some of the services provided may be non-covered services by the Insurance Program and/or other medical insurance. This is not a statement by the insurance company that the service was unnecessary, but rather a reason for rejection of payment by the insurance company.

Missed Appointments

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand and agree to this Financial Policy.

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Patient Communication

Voice Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. _____ (initial)

Email: *(edit with regard to the practice's use of secure electronic communication)* Except for appointment reminders, we use secure methods to electronically communicate with our patients**. Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address.

☐ *I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time. My email address is* _____

Cellphone:

☐ I consent to the dental practice using my cellphone number to (choose one or both) □ call or □ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

My cellphone number is (include area code) _____ _____ (initial)

Patient Acknowledgements

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

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