New Patient Information

ArrowFamilyDentistry.com - (909) 987 5522

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____

Cell: (____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City_____ State_____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date:___/___/___ Relation: _____

Billing Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation:_____

SPOUSE INFORMATION

[ ] Same as above Name: _____ Birth date: ___/___/___

Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

MEDICAL HISTORY INFORMATION

Name of Physician: _____ Phone: (____) _____

Do you have or have ever had any of the following? Please check those that apply:

[ ] Allergies/Hay Fever	[ ] Diabetes	[ ] Heart Surgery*	[ ] Rheumatic Fever
[ ] Anemia	[ ] Epilepsy or Seizures	[ ] Hepatitis	[ ] Rheumatism
[ ] Angina	[ ] Excessive Thirst	[ ] High Blood Pressure	[ ] Sickle Cell Disease
[ ] Arthritis	[ ] Fainting or Dizziness	[ ] HIV*/AIDS	[ ] Sinus Problems
[ ] Artificial Joints*	[ ] Fever Blisters/Cold Sores	[ ] Kidney Problems	[ ] Stroke
[ ] Artificial Heart Valves*	[ ] Frequent Cough	[ ] Liver Problems	[ ] Surgical Shunt*
[ ] Asthma	[ ] Glaucoma	[ ] Mental Disorders	[ ] Thyroid Problems
[ ] Breathing Problems	[ ] Heart Disorder (Congenital)*	[ ] Mitral Valve Prolapse*	[ ] Tuberculosis
[ ] Cancer	[ ] Heart Infection*	[ ] Osteoporosis	[ ] Ulcers
[ ] Chemical Dependency	[ ] Heart Murmur*	[ ] Radiation Treatment	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Heart Pace Maker*	[ ] Respiratory Problems	[ ] Yellow Jaundice

* This condition may require antibiotic premedication for certain dental procedures.

YES NO

[ ] [ ] Do you have any health problems that were not listed above or need further clarifications?
If yes, explain: _____

[ ] [ ] Are you now under the care of a physician?
If yes, explain: _____

[ ] [ ] Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, explain: _____

[ ] [ ] Are you taking any medications or herbals?
If yes, list: _____

[ ] [ ] Are you allergic to any medications or substances?
If yes, please check box below:
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Iodine [ ] Metal [ ] Latex [ ] Other _____

[ ] [ ] Have you used tobacco?
If yes, explain: _____

WOMEN (Please check): [ ] Pregnant [ ] Trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date _____
Signature of patient, parent or guardian

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it states past and present conditions.

Date:	Exceptions:	Patient's Signature:
_____	_____ [ ] None	X _____
_____	_____ [ ] None	X _____
_____	_____ [ ] None	X _____

DENTAL HEALTH QUESTIONNAIRE

We believe that each patient deserves to know what their current level of dental health is, how they got there, and what treatment options are available to help them reach the level of health that they deserve. This begins with a careful diagnosis and personalized treatment plan. We will perform a comprehensive oral examination of your teeth, gums, jaw joints, bite and soft tissues. We will also take the appropriate x-rays, and when beneficial we may take additional diagnostic records such as photographs or casts of your teeth to further evaluate areas of concern.

Once all your records have been completed they will be carefully evaluated to determine your current level of dental health and how you got there. We will review our findings with you and discuss your treatment options. A personalized treatment plan will then be developed to help you achieve the goals we set together.

Please help us better understand your dental health needs and goals by answering the following questions.
(check the best answer):

1. Have you had a full mouth set of x-rays (other than routine cavity detecting x-rays) within the last 3 years? [ ] **Yes** [ ] **No**
2. I have a [ ] **low** [ ] **moderate** [ ] **high** fear of going to the dentist.
3. My mouth and teeth are [ ] **very** [ ] **moderately** [ ] **not comfortable**.
4. I am [ ] **very satisfied** [ ] **satisfied** [ ] **dissatisfied** with the appearance of my teeth.
5. I think my present state of dental health is [ ] **excellent** [ ] **good** [ ] **fair** [ ] **poor**.
6. I would say that my main concerns with my dental health are: _____
7. I am interested in a smile evaluation and personalized treatment plan to enhance my smile. [ ] Yes [ ] No
8. Please check which statement below best represents the level of dental health you wish to achieve.
   (Some people begin at one level and progress to a higher level over time.)

   [ ] **HEALTH LEVEL I - Emergency Care**
   I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment.
   I am not very interested in thinking about the future of my teeth at this time.

   [ ] **HEALTH LEVEL II - Maintenance Care**
   I am interested in maintenance care by taking an active part in the prevention of the disease process and the repair of existing problems. However, I am not yet ready for a higher level of dental care due to limitations of time and/or money. I understand that maintenance care may not be enough to help me achieve maximum protection and longevity and that my dental health may not remain stable over time.

   [ ] **HEALTH LEVEL III - Comprehensive Care**
   I am interested in comprehensive care to achieve and maintain a higher level of dental health.
   I am concerned about treating the causes of dental diseases, not simply the effects.
   I want all dental treatment provided to be the best available for maximum protection and longevity, so as to achieve long-term stable dental health.

   [ ] **HEALTH LEVEL IV - Comprehensive & Cosmetic Care**
   I am interested in comprehensive and cosmetic care to achieve and maintain the highest level of dental health.
   I am concerned about treating the causes of dental diseases, not simply the effects.
   I want all dental treatment provided to be the best available in cosmetic dentistry for maximum protection, longevity, and esthetics, so as to achieve long-term stable, yet esthetic, dental health.

APPOINTMENTS

We value your time so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advanced notification** so that we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Unless another financial option is PRE-ARRANGED, payment in full is due the day of treatment, or on pre-op visits for sedation appointments. Should a patient have dental insurance with assignment to Dr. Angelova, the estimated patient portion will be the amount due. Insurance payments without assignment will be sent to the insured with payment due in full.

Payment Options

1. For your convenience we accept Cash, Check, Visa, MasterCard, Amex & Discover.
2. We also offer short and long-term financing options. (Interest-free options may apply)

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. Your dental benefits and how they relate to your specific needs will be explained to you during the Treatment Discussion appointment.

Finance Charge and Fees

- Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).
- Returned checks are subject to a $15 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Angelova. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Angelova to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Angelova.

Photography Release

I authorize Dr. Angelova to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize him to show these photographs to other patients to better explain their treatment options.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize **Photographs** to be taken of me and shown to other patients.

X _____ Date _____
Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

I understand that I may ask any questions I might have regarding this notice.

Signature _____ Date _____