ESCALA FAMILY DENTISTRY
Affordable Dental Care for Children and Adults

Confidential Patient Information

Date _____

PERSONAL INFORMATION

Name _____
Social Security # _____
Address _____
_____
City _____
State _____ Zip_____
Home Phone # _____
Work Phone # _____
Cell Phone # _____
Emergency contact name _____
Emergency contact Phone # _____
E-mail _____
Birth date _____ Sex _____
Marital Status _____
Spouse name _____
Occupation _____
Languages you speak _____
How did you hear of our office? _____
_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Employee (Policy Holder) _____
Relationship _____
S.S. # of Policy Holder _____
Birth date of Policy Holder _____
Employer _____
Policy # _____

Secondary Insurance Co. _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Employee (Policy Holder) _____
Relationship _____
S.S. # of Policy Holder _____
Birth date of Policy Holder _____
Employer _____
Policy # _____

PERSON RESPONSIBLE FOR ACCOUNT (If same as above, skip to next section)

Name _____ Relationship _____ S.S. # _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____

DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ Date of last dental visit _____

I understand that payment is my obligation regardless of insurance or any other third party involvement.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

Patient name _____ Birth date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions completely and honestly.

PLEASE EXPLAIN ANY "YES" RESPONSES ON THE LINES PROVIDED.

Are you under a physician's care now? ___Yes ___No _____
Have you ever been hospitalized or had a major operation? ___Yes ___No _____
Have you ever had a serious head or neck injury? ___Yes ___No _____
Are you taking any medications, pills, drugs, or vitamins? ___Yes ___No _____
Please list all medications you currently take _____
_____
Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No
_____
Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? ___Yes ___No _____
Are you on a special diet? ___Yes ___No
_____
Do you use tobacco? ___Yes ___No _____
Do you use controlled substances? ___Yes ___No _____

FOR WOMEN ONLY: Are you…

Currently pregnant? ___Yes ___No
Trying to get pregnant? ___Yes ___No
Taking oral contraceptives? ___Yes ___No
Nursing? ___Yes ___No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa drugs
___Other (please explain) _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

AIDS/HIV positive ___Yes ___No	Cortisone Medicine ___Yes ___No	Hemophilia ___Yes ___No	Radiation Treatments ___Yes ___No
Alzheimer's disease ___Yes ___No	Diabetes ___Yes ___No	Hepatitis A ___Yes ___No	Recent Weight Loss ___Yes ___No
Anaphylaxis ___Yes ___No	Drug Addiction ___Yes ___No	Hepatitis B or C ___Yes ___No	Renal Dialysis ___Yes ___No
Anemia ___Yes ___No	Easily Winded ___Yes ___No	Herpes ___Yes ___No	Rheumatic Fever ___Yes ___No
Angina ___Yes ___No	Emphysema ___Yes ___No	High Blood Pressure ___Yes ___No	Rheumatism ___Yes ___No
Arthritis/Gout ___Yes ___No	Epilepsy/Seizures ___Yes ___No	High Cholesterol ___Yes ___No	Scarlet Fever ___Yes ___No
Artificial Heart Valve ___Yes ___No	Excessive Bleeding ___Yes ___No	Hives or Rash ___Yes ___No	Shingles ___Yes ___No
Artificial Joint ___Yes ___No	Excessive Thirst ___Yes ___No	Hypoglycemia ___Yes ___No	Sickle Cell Disease ___Yes ___No
Asthma ___Yes ___No	Fainting/Dizziness ___Yes ___No	Irregular Heartbeat ___Yes ___No	Sinus Trouble ___Yes ___No
Blood Disease ___Yes ___No	Frequent Cough ___Yes ___No	Kidney Problems ___Yes ___No	Spina Bifida ___Yes ___No
Blood Transfusion ___Yes ___No	Frequent Diarrhea ___Yes ___No	Leukemia ___Yes ___No	Stomach/Intestinal Disease ___Yes ___No
Breathing Problem ___Yes ___No	Frequent Headaches ___Yes ___No	Liver Disease ___Yes ___No	Stroke ___Yes ___No
Bruise easily ___Yes ___No	Genital Herpes ___Yes ___No	Low Blood Pressure ___Yes ___No	Swelling of Limbs ___Yes ___No
Cancer ___Yes ___No	Glaucoma ___Yes ___No	Lung Disease ___Yes ___No	Thyroid Disease ___Yes ___No
Chemotherapy ___Yes ___No	Hay Fever ___Yes ___No	Mitral Valve Prolapse ___Yes ___No	Tonsillitis ___Yes ___No
Chest Pains ___Yes ___No	Heart Attack/Failure ___Yes ___No	Osteoporosis ___Yes ___No	Tuberculosis ___Yes ___No
Cold Sores/Fever Blisters ___Yes ___No	Heart Murmur ___Yes ___No	Pain in Jaw Joints ___Yes ___No	Tumors or Growths ___Yes ___No
Congenital Heart Disorder ___Yes ___No	Heart Pacemaker ___Yes ___No	Parathyroid Disease ___Yes ___No	Ulcers ___Yes ___No
Convulsions ___Yes ___No	Heart Trouble/Disease ___Yes ___No	Psychiatric Care ___Yes ___No	Venereal Disease ___Yes ___No
			Yellow Jaundice ___Yes ___No

Have you ever had any serious illness not listed above? ___Yes ___No _____

Comments: _____
_____
_____
_____

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

Signature of Patient, Parent or Guardian _____ **Date** _____

ESCALA FAMILY DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify) _____

ESCALA FAMILY DENTISTRY
Family, Cosmetic & Implant Dentistry

FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Insurance Information and Financial Agreement:
As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January –December). **All estimates are obtained from your insurance company. We cannot guarantee what will be paid by insurance. Any portion that is not paid by your insurance will be your responsibility. All of our doctors will diagnose treatment based on your dental health not your insurance coverage.** (_____)
Payments may be made using cash, check, Flex account cards, Visa, Mastercard and/or Discover. We also offer CARECREDIT and Lending Club Financial, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance that needs to be paid within 30 days. After 90 days, if there is no payment we will send account to collection agency to collect debt. (_____)

Appointments:
In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. **We require a 2- business day notice for any cancelled appointment. If you cancel your appointment within the 2-business days, you will be charged a fee of $50.00 up to the cost of the appointment, that will be applied to your account. If you have a credit on your account, these fees will be paid with that credit.** We will call up to 2 days before your appointment to confirm that you will be at your appointment. If we don't get the verbal confirmation we will cancel your appointment and add the cancellation fee. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours. (_____)

Refund Policy:
When we offer a procedure with a discount, we are doing some treatment at no cost as a courtesy to the patient. When a refund is requested by patient the discounted plan is going to be voided. The plan at that time will go back to full cost. For example, if you do a denture with implants and half way through the procedure you decide to stop treatment. The procedures that are completed will be charged at full price and the fund that has been paid will be used to pay for those procedures. The remainder money that is left will be refunded back to patient. All refunds will require an audit of the account and approval from Dr. Escala. (_____)

Patient's Name (Printed) Date

Patients signature Date

We strive to give all patients the same care. We will help all patients with their insurance claims. It ultimately is the patients responsibly to know about the insurance. If you have any concerns with what they are paying it is the patients responsibility to contact them directly.

Insurance Financial Waiver

All patients that have dental insurance are allowed so much for the year. Any portion that is not covered by their insurance company, it is the patient's responsibility to pay the remainder balance.

Medicaid Financial Waiver

All adult Medicaid patients are allowed $1000.00 for the fiscal year (July 1st- June 30st). All children up to the age of 21 don't have a yearly max. For any reason that Medicaid does not pay for their treatment, it is patient's responsibility to pay for the remainder balance.

Signing this states that you are aware that you as a patient and/or guardian is responsible for the financial portion that your insurance does not cover.

Thank you,

Patient