REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Patient Is:

- ☐ Policy Holder
- ☐ Responsible Party

Responsible Party (if someone other than patient)
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip Code :_____
Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____
Birth Date: ____/____/_____ Soc Sec: _____ Drivers Lic: _____

Patient Information
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated
Birth Date: ____/____/_____ Soc Sec: _____Email: _____

Primary Insurance Information
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc Sec: ____-_____- _____ Insured Birth Date: _____/____/_____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Secondary Insurance
Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc Sec: ____-_____- _____ Insured Birth Date: _____/____/_____
Employer: _____Insurance Company: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

ASSIGNMENT AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, my spouse, or my child during the period of such Dental care to third party payers. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered to myself, my dependents or spouse.

_____

Signature of Patient or Parent if Minor Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire 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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain:_____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain:_____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux? ◯ Yes ◯ No If yes, please explain:_____
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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No
Taking oral contraceptives? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, 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 or 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 Spells/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	Tonsilitis ◯ 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 ◯ yea ◯ 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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____

Galen Filbrun,D.D.S.

ATD Screening Documentation -Patient Questionnaire

To ensure that our patients are treated in an environment that promotes health and well-being, and in accordance with Cal/OSHA requirements for providing a safe and healthful workplace, patients suffering from aerosol transmissible diseases such as mumps, chickenpox, measles, influenza, tuberculosis, or other illnesses that may be spread by airborne transmission should notify our office immediately.

Respiratory Hygiene and Cough Etiquette

During your time in our facility, please abide by the following practices recommended by the Centers for Disease Control and Prevention:

- Cover your nose and/or mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
- Wash your hands with soap and water or with alcohol-based hand sanitizer after you have had contact with potentially contaminated respiratory secretions.

Patient Information

Please fill out and return the completed questionnaire to the reception desk. If signed by the patient's guardian, please print full name next to the signature.

Patient's name _____

Contact information (email or phone)_____

Signature_____ **Date**_____

Are you suffering from any of the following signs or symptoms of aerosol transmissible illness?

Please mark (yes) or (no) for each question: Yes No

1. Do you currently have a respiratory illness?
2. Have you had a cough for at least 3 weeks not explained by noninfectious conditions?
3. Have you had coughing fits that interfere with eating, drinking, talking or breathing?
4. In addition to cough, are you currently experiencing, or experienced recently:
   - unexplained weight loss (more than *5* pounds)
   - night sweats
   - fever
   - chronic fatigue or malaise
   - coughing up blood
   - painful, swollen salivary glands
   - unexplained rash
   - stiff neck
5. Have you been exposed to anyone with an infectious aerosol transmissible illness other than seasonal influenza?

   (See below for list of such illnesses, and circle specific disease exposures.)

- Any flu other than seasonal flu
- Chickenpox
- Shingles
- Measles
- Monkeypox
- SARS
- Smallpox
- Tuberculosis
- Diphtheria
- Meningitis
- Mumps
- Pneumonia
- Parvovirus
- Pertussis (whooping cough)
- Pharyngitis
- Epstein-Barr virus
- Strep
- Scarlet fever

Our Financial Policy

Noninsured patients are expected to pay in full with cash, check, or credit card the day the service is rendered unless specific arrangements have been made in advance.

For those patients who are covered by insurance, we will accept assignment of benefits. This means that you must sign the portion of your insurance forms that "assigns" payment to our office. Most dental plans **do not cover 100%** of the cost of treatment. Because of this and extreme delay in payment from the insurance company, you will be asked to pay your portion as well as any deductible at the time of service. We will **estimate** as closely as possible your coverage, but until we actually receive payment from your insurance company, it is just an **estimate.** We will **assist** you in dealing with your insurance company, but the ultimate responsibility lies with you. After 45 days, the balance will due in full from you.

Our treatment coordinator is responsible for establishing all financial arrangements. We offer payment plans through Care credit for those patients interested in their services. Ask our treatment coordinator for details.

I , _____ ,understand that I am responsible for payment of services rendered and am responsible for paying any co-payment and deductibles that my insurance does not cover.

Patient Signature Date

Galen Filbrun D.D.S.

I have been given the opportunity to review a copy of this office's Notice of privacy Practices and Dental Materials Fact Sheet.

Printed Name_____

Signature_____

Date_____