DENTAL INSURANCE INFORMATION

This information is a confidential part of our patient records. Thank you.

Patient's Name:____

Full-time student Yes ☐ No ☐ School/City: ____________________________

Date of birth:_________________Age:___________________ Male ☐ Female ☐

PRIMARY DENTAL INSURANCE COMPANY INFORMATION

Group No: _________________________________

Ins. Company Name: ____

City: __________________________________State:_________________Zip:__________________

Phone No: area code: ( ) _____________________________

Insured's Name: ____

Address:____

City:____State:____________Zip:________

Date of Birth:________________________

Employer: _______________________

SECONDARY DENTAL INSURANCE COMPANY

Group No: _________________________________

Ins. Co. Name: ____

City: __________________________________State:_________________Zip:__________________

Phone No: area code: ( ) _____________________________

Insured's Name: ____

Address:____

City:____State:____________Zip:________

Date of Birth:________________________

Employer: _______________________

϶ Please call our office if you require assistance in filling out this form. We would be happy to assist you. (650) 994 –1818 … or 994-1812

For Office use only	For Office use only	For Office use only
PRIMARY	SECONDARY	TRANSFER PATIENT
Lifetime Max:__________	Lifetime Max:__________	Lifetime Max:_________
%_________	%_________	%_____________
Ded. Met: Yes No	Ded. Met: Yes No	Ded: Met Yes No
Amount Used: __________	Amount Used: __________	Amount Used:_________
Remaining: ____________	Remaining: ____________	Remaining:____________
		Pt:. prior paid: _________

DENTAL HISTORY – ADULT Date________________________

This information is a confidential part of our patient records.

Have you ever received a severe blow resulting in injury to the teeth or jaws?_______Yes □ No □

If yes, please write dates and details below:---

In the past have you ever experienced:

Clicking, popping or grating noises of the jaw joints in front of each ear?............Yes □ No □

Stiffness or soreness of the jaws and jaw muscles?..Yes □ No □

Episodes when the jaws would not open or close normally?.................................Yes □ No □

Pain or discomfort in the area in front of the ears?..Yes □ No □

If so, please write details below

____

____

Do you have or do you use any of the following :

Teeth sensitive to cold, heat, sweets or pressure when biting....................................... Yes □ No □

Bleeding gums after brushing your teeth..Yes □ No □

Food impaction between teeth... Yes □ No □

]Swelling or lumps in your mouth.. Yes □ No □

Mouth breathing, chronic stuffy nose..Yes □ No □

Cigarettes, pipe or cigar smoking.. Yes □ No □

Any mouth sores, lips, that have not healed for a long time..Yes □ No □

Texture of your toothbrush: Hard] Soft] Medium]

How many times a day do you brush your teeth? ________________

Have you had any periodontal surgery (gums,"pocket" reduction)..................................Yes □ No □

Oral habits such as: fingernail biting □ lip biting □ cheek biting □ other □

Please describe any *recent* dental treatment you have had with your family dentist. Have you noticed any changes in your "bite" since that time? Or, does all feel well with your ability to chew____

____

MEDICAL HISTORY - ADULT

This information is a confidential part of our patient records.

Patient's Physician Dr.____

Physician's address ____

Has patient had tonsils or adenoids removed? ____________________________ Yes ☐ No ☐

Has patient ever had an unusual reaction to any drug such as penicillin or

local anesthetic?____Yes ☐ No ☐

If yes, to what?____

Please circle if you have/or have had any of the following:

Arthritis	Allergies
Anemia	Asthma
Bleeding problem	Rheumatic fever
Cancer	Major surgery
Epilepsy	Tuberculosis
Nervous disorders	Heart conditions
Hyperactivity	Previous orthodontics
Mental retardation	Thyroid/hormonal imbalance
Emotional problems	HIV-positive diagnosis
Diabetes	Any other medical problems
Frequent colds	Blood disorders
Joint disorders	Are you pregnant?

Is there any concern that you have contracted AIDS?..................................

Is patient presently under the care of a physician or receiving any medication?

If yes, please explain____

Signature ____Date__________________________

Please list any other comments you feel may be helpful or pertinent to the medical or dental history of this patient____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize your office to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Other payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practice*s, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ______day of ___________, 20______.

Please print Patient's Name: ____

Relationship to Patient:____

Signature:____

Ernest A. Maggioncalda, D.D.S., Inc.
4943 Junipero Serra Blvd.
Colma, CA. 94014 (650) 994-1818

PERSONAL INFORMATION - ADULT

Date____________________

This information is a confidential part of our patient records.

Patient's name____Date of Birth___________

Last First Middle

Your address____ Home Phone ( )________

Street Number and name

Cell: # ( )_______________

--S.S. #_________________

City, State, Zip code

Employer____Occupation_____________

Address____Phone # ( )___________

Street numer and name

____

City, State, Zip code

Spouse's name____Date of Birth_____________

Spouse's employer_____________________________________Occupation______________

Employer's address_____________________________________ Phone # ( )____________

Spouse's S.S. # ______________________ Spouse's Cell:# ( )____________

If transfer patient from another office, please note former orthodontist and address:

Dr. _______________________________________Phone # ( )_________________________

____

Street number City, State, Zip Code

Other family members a former or present patient at our office?

____

Please note your primary complaint regarding your teeth

____

____

Patient's general dentist: Dr. ____

____

Street number and name City State Zip