Paso Robles Dental Care
Von Joseph Holbrook, DDS

Patient's Name: Sex: Birthdate:

Mailing Address: City: State: Zip:

Social Security #: Home Phone: Cell Phone:

Occupation: Employer: Employer Phone:

Emergency Contact: Emergency Contact Phone:

Email Address: **How did you hear about our office?**

If Patient is a Minor:

Mother's Name/DOB Father's Name/DOB:

Dental Insurance Information

Policy Holder

SSN or ID # DOB:

Employer:

Insurance Co.

Provider Phone #

Secondary Dental Insurance Information

Policy Holder

SSN or ID # DOB:

Employer:

Insurance Co.

Provider Phone#

Certification

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health.

Patient Signature: Today's Date

522 13th St, Paso Robles, CA 93446 · Phone: (805)237-7773 · Fax (805)465-6051 · Email: prdentalcare@gmail.com

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Medical Health History

Patient Name: _____

Do you have or have you had any of the following?
(Please check all that apply- or NONE)

- ☐ Abnormal Bleeding after extractions, surgery, or trauma
- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia or Blood disorders
- ☐ Arthritis/Gout/Rheumatism
- ☐ Artificial Joint or Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer Type: _____
- ☐ Diabetes Type: _____
- ☐ Drug/Alcohol addiction
- ☐ Radiation/Chemo Therapy
- ☐ Epilepsy, seizures, or fainting spells/dizziness
- ☐ Frequent Headaches/Migraines
- ☐ Have taken bisphosphonates
- ☐ Heart Ailment or Angina
- ☐ Heart Murmur/Mitral valve Prolapse/Heart Defect
- ☐ Hepatitis Type: _____
- ☐ Herpes/Cold Sores/Fever Blisters
- ☐ High Blood Pressure
- ☐ Kidney Problems/disease
- ☐ Neurologic Condition
- ☐ Osteoporosis/Osteopenia/ Osteonecrosis
- ☐ Recent Surgery
- ☐ Pacemaker
- ☐ Psychiatric care / Nervous/ Anxious
- ☐ Rheumatic Fever/Rheumatic Heart Disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tobacco use
- ☐ Tuberculosis or other lung problems
- ☐ Tumors or Growths
- ☐ Any other conditions not listed?
- ☐ NONE

If checked yes, please provide details including dates:

_____

Are you currently taking any medications, pills, drugs, including marijuana? Yes/No
Please list:

_____

Do you have a physician? Yes/No
Name:

_____

Women only

- ☐ Pregnant
- ☐ Nursing
- ☐ Taking Oral Contraceptives

Are you allergic to any of the following?
(Please check all that apply- or NONE)

- ☐ Aspirin
- ☐ Metal
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Latex
- ☐ Codeine
- ☐ Acrylic
- ☐ Local Anesthetics
- ☐ Sulfa Drugs
- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil/Motrin)
- ☐ Other: Please list _____
- ☐ NONE

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.

Patient Signature: _____ Today's Date _____

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Patient Name: _____

Acknowledgement of Receipt of Dental Materials Fact Sheet

I have been given a copy of the Dental Materials Fact Sheet provided by the California Dental Association.

_____[Please Print Name]

_____[Signature]

_____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient _____

Acknowledgement of Receipt of Privacy Practices

I have been informed and given a copy of the "Notice of Privacy Practices" for Paso Robles Dental Care containing a more complete description of the uses and disclosures of my health information.

_____[Please Print Name]

_____[Signature]

_____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient _____

Permission to Share Medical/Dental Information:

(Including a spouse; optional- you may leave this section blank)

My medical/dental information may be obtained and/or exchanged written or verbally to:

_____[Please Print Name]

_____[Relationship]

_____[Patient or Guardian Signature]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient _____

For Program Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

- ☐Individual refused to sign
- ☐Communications barriers prohibited obtaining the acknowledgement
- ☐An emergency situation prevented us from obtaining acknowledgement
- ☐Other (Please Specify)

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Patient Name: _____

Office Policies

Appointment Policy

We are dedicated to staying on schedule and seeing all of our patients at the time of their appointment. Please note that we may have to reschedule any appointment that is more than 10 minutes late. Being that we reserve time especially for you, if you need to change an appointment, we ask for a minimum notice of 48 hours. Consecutive failed appointments can result in needing to pay a deposit to schedule, or being dismissed as a patient. The deposit will be forfeited as a cancellation fee if the appointment is changed without proper notice. The deposit will remain on account as long as there is an appointment on schedule or if it's been forfeited due to failed appointment.

_____

Financial Policy

Our office accepts all major credit cards, cash and Care Credit. All co-payments are due in full by the time of service. Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for your appointment, we require a deposit of 40% to make your reservation. If the appointment is changed without proper notice, $50 of the deposit will be forfeited to the cancellation fee and will require repayment of $50 to reschedule.

_____

Insurance Policy

We can bill all PPO insurance plans and will gladly bill your insurance for you. However, we remind you that billing your insurance is a courtesy to you from our office. Your insurance policy is a contract between you, your employer and your insurance company; we cannot make any guarantee of any estimates we provide you, though we will do our best to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

_____

Standard of Care Policy

Our primary concern is your complete oral health. We strive to provide all of our patients with the best standard of care possible. We require x-rays prior to your first prophylaxis (cleaning) and recommend checkup radiographs once a year and full mouth radiographs every 5 years. It is the returning patient's option to decline radiographs, though only for a period of 14 months. Warranty of work will be contingent upon maintaining continued preventive care with our office.

_____

If you have any questions about the Office Policies please speak with any of the dental staff.

I understand and agree to abide by Paso Robles Dental Care Office Policies

Patient Signature: _____ Today's Date _____

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