Pebblebrooke
DENTISTRY

Full Name _____ **Preferred Name** _____

Date of Birth _____ **SSN:** _____ **Gender:** Male/Female

Family Status: Married/ Single/ Child/ Other **Email Address** _____

Address _____
Street City, State Zip Code

Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____ **Other** (____) _____-_____

How did you hear about us? _____

Dental History

What was the approximate date of your last dental visit? _____

What was performed? _____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

Reason for your visit today:

_____

Medical History

Primary Care Physician's name, address, and phone number:

_____

Have you been hospitalized within the last 5 years due to a surgery or illness? If yes, please explain:

_____

Please list any current medications that you are taking (we can scan a list if you have it):

_____

_____

Please indicate if you are allergic to any of the following:

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Metal ☐ Motrin (Ibuprofen)

☐ Latex ☐ Local Anesthetic ☐ Epinephrine ☐ Sulfa ☐ Acetaminophen (Tylenol)

☐ Other: _____ ☐

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Please indicate if you have experienced any of the following:

☐ Anemia	☐ Alzheimer's	☐ Arthritis
☐ Artificial Joints	☐ Aspirin Therapy	☐ Autism
☐ Asthma	☐ Blood Disease	☐ Auto Immune Disease
☐ Blood Thinners	☐ Chemotherapy	☐ Cancer
☐ Currently Pregnant	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Fainting	☐ Glaucoma
☐ Gluten Allergy	☐ Head/Neck Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis A	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Kidney Disease	☐ Liver Disease
☐ Low Blood Pressure	☐ Mental Disorders	☐ Mitral Valve Prolapse
☐ Nervous Disorders	☐ Osteoporosis Meds	☐ Pacemaker
☐ Pre-Medication	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Seasonal Allergies	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease
☐ Tuberculosis	☐ Ulcers/Cold Sores/Fever Blisters	☐ Tumors
☐ Vertigo	☐ Heart Stents	☐ Venereal Disease

Please list any other illnesses you may have that are not listed above:

_____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail. I hereby certify that I have read and understand the previous information, and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I may be billed for this remaining balance. I consent and agree fully to be financially responsible for payment of all services rendered on my behalf, or on behalf of my dependents (if any).

_____

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

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DENTISTRY

PLEASE READ CAREFULLY AND COMPLETE THIS FORM ONLY IF YOU HAVE DENTAL INSURANCE

Due to changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Our office does not participate with any insurance networks. If your plan allows you to choose any provider you wish, then you are able to use your benefits in our office. However, since we are an out-of-network provider, it is not possible for us to know exactly how much your insurance will pay. We can only estimate based on the insurance information that is provided to us. Please remember that your insurance policy is a contract between you and your insurance company, not with your doctor.

We will be happy to help you by filing your insurance claim for you. You may pay for your treatment in full, and have your insurance company reimburse you directly. This is our preferred method as it prevents billing, and is a very direct and hassle-free approach. If you would rather our office wait on the payment from the insurance company, we will collect only your estimated co-payment at the time of service. After we submit the claim to the insurance company, you may receive a statement for any leftover balance.

There are some insurance companies that will NOT issue us a check because we are an out-of-network provider. If this is the case, you will have to pay in full at the time of service, and you will be directly reimbursed.

I understand Pebblebrooke Dentistry's insurance policy that is stated above. I also understand that if I do not pay in full at the time of service, I may receive a statement for any remaining balance not covered by my insurance company. It is my responsibility to pay this balance, as the services were rendered to me by Dr. Campos.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Relationship to Patient

Pebblebrooke
DENTISTRY

Dear Patient,

Here at Pebblebrooke Dentistry, we strive to render excellent dental care to you, your family, and all of our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside ample time for a patient dependent on the patient's current needs. Our office hours are by appointment, and we value your time. This office is a private practice dental office, and not a dental "clinic." Appointments are reserved for you alone. Like many offices, we do try to contact you to confirm your appointment. Please do not depend on this courtesy. If you cannot make an appointment as scheduled, please notify our office. There will be a charge of $30 for any missed appointments, or any appointments cancelled or rescheduled without 48 hours' notice. (This amount is subject to change depending on the amount of time we have reserved for you.) We do understand that extreme or unavoidable emergencies or circumstances do arise and individual circumstances will be taken into consideration. We also know that delays can happen, however we must try to keep our patients and doctor on time to the appointments we have scheduled for the day. Any patients who arrive more than 15 minutes late to their appointment will be rescheduled. This policy helps ensure that everyone is seen in a timely manner, and helps to reduce wait times. Patients who repeatedly miss appointments without providing proper notice will result in termination from the practice. We appreciate your understanding and patronage in this matter. If you have any questions or concerns regarding this policy, please feel free to ask us!

I have read and understand Pebblebrooke Dentistry's Appointment Policy, and agree to be bound by its terms.

_____ _____
Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____
Printed Name Date