COASTAL VALLEY DENTAL
SANTA MARIA

Patient Registration

Name _____ Date _____
First Mi. Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS#/SIN _____ Email _____

Home Phone _____ Cell Phone _____ Drivers License # _____

Are You: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Employer _____ Occupation _____ Work Phone _____

Spouse or Parent/Guardian Name _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Who may we thank for referring you? _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SS#/SIN _____ Employer _____

Home Phone _____ Cell Phone _____ Drivers License # _____

Insurance Information

Name of insured _____ Phone _____ Relationship _____

Birthdate _____ SS#/SIN _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance:

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State/Zip _____

Suscriber ID # _____ Group # _____

Secondary Insurance:

Name of insured _____ Phone _____ Relationship _____

Birthdate _____ SS#/SIN _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Phone _____

Insurance Address _____ City _____ State/Zip _____

Suscriber ID # _____ Group # _____

COASTAL VALLEY DENTAL
SANTA MARIA

Patient's Name _____ Date _____

Dental History

Reason for today's visit _____

Former Dentist (Name & Location) _____ Phone _____

Date of last dental visit _____ Date of last dental x-rays _____

Does dental treatment make you apprehensive? ☐ no ☐ slightly ☐ extremely

Medical History

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Do you have or have you every had any of the following? Please mark Yes or No for each item listed

AIDS/HIV infection	Yes No	Diabetes	Yes No	Mental Health Care	Yes No
Anemia	Yes No	Eating Disorders	Yes No	Mitral Valve Prolapse	Yes No
Artificial Joints	Yes No	Epilepsy/Seizures	Yes No	Pacemaker	Yes No
Asthma	Yes No	Fen-phen (diet drugs)	Yes No	Respiratory Disease	Yes No
Back Problems	Yes No	Heart Murmur/Defect	Yes No	Sinus Infections	Yes No
Bisphosphonate Use	Yes No	Heart Problems	Yes No	Stroke	Yes No
Cancer	Yes No	Prolonged Bleeding	Yes No	Thyroid Problems	Yes No
Chemical Dependency	Yes No	Hepatitis A, B, or C	Yes No	Tobacco Use	Yes No
Chemotherapy/Radiation	Yes No	High Blood Pressure	Yes No	Tumors	Yes No
Cold sores/Blisters	Yes No	Jaw Pain	Yes No	Tuberculosis	Yes No
Congenital Heart Defect	Yes No	Kidney Disease	Yes No	Ulcers	Yes No
Cortisone Treatment	Yes No	Liver Disease	Yes No		

Do you require a preventative antibioitic before dental treatment? ☐ Yes ☐ No

Medications

List all medications you are taking, including non-prescription: _____

_____

_____

_____

Allergies

☐ Aspirin
☐ Barbiturates or sedatives
☐ Codeine
☐ Latex
☐ Local anesthetics
☐ Penicillin
☐ Sulfa
☐ Other _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any member of their staff responsible for any errors or omissions that I made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

COASTAL VALLEY DENTAL
SANTA MARIA

Financial/HIPAA/Patient Release

Thank you for choosing Coastal Valley Dental. We appreciate the opportunity to care for you and your family's dental needs. We are pleased to help you with your insurance (if applicable); however, you are ultimately responsible for payment of your bill. The following information is provided to answer questions and avoid confusion regarding payment for dental services.

Authorization to release information: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment via electronic transmissions, including emails with our special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

Please circle: Spouse / Parent / Child / Other _____

Signature of Patient/Legal Guardian: _____ Date: _____

Acknowledgement of receipt of Notice of Privacy Practice AND Notice of Material: I hereby acknowledge that I have reviewed the Notice of Privacy Practices and Dental Material Fact Sheet on coastalvalleydental.com. I further acknowledge that I have the right to request a copy of the notice and one will be provided for me.

Signature of Patient/Legal Guardian: _____ Date: _____

Financial Responsibility:

I authorize and request my insurance to pay directly to the dentist or dental group 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 payment of all services rendered on my behalf of my dependents.

For patients with dental benefits: As a courtesy, our office will file your claim with your insurance company and work with the company to provide the necessary information to maximize your benefits. Any amount not received from your insurance company is your responsibility. All copays are due on day of treatment.

For patients without dental benefits: If you do not have dental insurance, you will be responsible for the full cost of your treatment. Payment for services is due at the time of treatment.

We accept cash, personal checks, and the following credit cards: Visa and Mastercard

Appointments missed or cancelled less than 48 hours in advance will be charged a $75 fee _____
Initial

Signature of Patient/Legal Guardian: _____ Date: _____