

WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date	Occi									
SS/HIC/Patient ID #	Patie	ent Employer/Schoo	ol							
Patient Name		Employer/School Address								
Address										
City		lover/School Phone	e ()							
State Zip										
E-mail			SS#							
Sex \square M \square F Age Birthday										
☐ Married ☐ Widowed ☐ Single	gle □ Minor Who	Whom may we thank for referring you?								
☐ Separated ☐ Divorced ☐ Par	tnered for years									
	Dental Inst	urano	e.							
Subscriber's Name			econdary insurance? ☐ Yes ☐ No							
Relationship to Patient										
Birthday SS#										
Insurance Co.			SS#							
Group # Phone										
Group # Priorie										
	Grou	ıp #	Phone ()							
Home Phone ()		Ext	Cell Phone ()							
IN CASE OF EMERGENCY, CONTACT (Speci	ify someone who does not live in your ho	usehold.)								
Name	Rela	itionship								
Home Phone ()										
Reason for today's visit	Dental H Please check (☑) "yes" or "no"	<i>.</i>	have had any of the following:							
Trodoon for today o viole	Bad breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No						
	Bleeding gums	☐ Yes ☐ No	Lip or check biting	☐ Yes ☐ No						
Former Dentist	Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No						
	Burning Sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No						
City/State		☐ Yes ☐ No	Mouth pain	☐ Yes ☐ No						
Date of last dental visit	Clighting or paging law	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No						
Date of last dental X-ray	Clicking or popping jaw Dry mouth	☐ Yes ☐ No	Pain around ear Periodontal treatment	☐ Yes ☐ No						
	Fingernail hiting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No						
How often do you floss?	Food collection between the teeth		Sensitivity to heat	□ Yes □ No						
How often do you brush?		☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No						
Do you wear contact lenses? ☐ Yes ☐ N	Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No						
, , , , , , , , , , , , , , , , , , , ,	Outris swoller of terider	☐ Yes ☐ No	Sores or growths in mouth	☐ Yes ☐ No						
	-0 V E R-									

Medical History

Please check (29) "Yes" or "no" to indicate if you have had any of the following: ADS	Physician's Name					Date	of last visit					
Please check (g) "Yes" or mo" to Indicate if you have had any of the following: Similar Sim	Phone ()		P	harmacy								
Anemia vis No High Blood Pressure vis No Antmiss Piss No Antmiss Piss No Authmiss Piss No No Authmiss Piss No Authmiss P												
Anchrids Ves No Asthma Ves No Cander Ves No No No No No No No N				LP de Discol Description	ΠYes	П Мо	Tonsillitis	П Уез	П №			
Asthma Yes No Asthma Yes No Back Problem Yes No Cancer Yes No Chemical Dependency Yes No No Chemical Dependency Yes No Schrifted Dependency Yes No Yes Yes No Yes Yes				•								
Back Problem	Arthritis, Rheumatism	☐ Yes	□ No		☐ Yes	□No						
Cancer Yas No Liver Disease Yas No Chemical Departedney Yas No Chemical Departedney Yas No No Chemical Departedney Yas No Cortisone Yas No No Cortisone Yas No No No Cortisone Yas No No Cortisone Yas No No Yas Y	Asthma	☐ Yes	□ No	Jaw Pain	☐ Yes	□ No						
Chemide Pependency Yes No Corruination Pressure New No New	Back Problem	☐ Yes	□ No	Kidney Disease	☐ Yes	□ No	Venereal Disease	☐ Yes	□ No			
Chemotherapy Yes No Narvous Problems Yes No Cortisone Treatments Yes No Radiation Treatment Yes No Cortisone Treatments Yes No Diabotes Yes No No Cortisone Treatments Yes No Diabotes Yes No No Cortisone Treatments Yes No Yes No No				Liver Disease	☐ Yes	□ No						
Circulatory Problems Ses No Cordisone Treatment Yes No Cough, persistent or bloody Yes No Cough, persistent or surgery Yes No Cough, persistent or bloody Yes No Cough, persistent or blood Disease Yes No Cough, persistent or bloody Yes No Cough, persistent or blood Yes No Cough, persistent or bloody Yes No Cough, persistent or blood	•					Have you ever had or been	diagnosed	with:				
Corlisone Treatments							Artificial Heart Valves	☐ Yes	□ No			
Coutp, persistent or bloody Yes No Clabetes Yes No Cardet Fever Yes No Emphysema Yes No Sandet Fever Yes No Emphysema Yes No Sandet Fever Yes No Sandet Feve												
Diabetes Yes No Property Yes No								☐ Yes	□ No			
Emphysiona Yes No Shortness of Breath Yes No Shortness Yes No Thyroid Problems												
Epilepsy Yes No Sinus Trouble Yes No Yes No Sinus Trouble Yes No Yes No Sinus Trouble Yes No Sinus Trauble Yes No Sinu												
Fainting Yes No Special DietWeight Loss Yes No Hernia Repair Yes No Hernia Repair Yes No Hernia Repair Yes No Hernia Repair Yes No No Hernia Repair Yes No Yes No Yes Yes No Yes No Yes Yes Yes No Yes Yes Yes No Yes												
Galacoma Yes No Stroke Yes No Stroke Yes No Stroke Yes No Head aches Yes No Head aches Yes No Stroke Yes No Head aches Yes No	Fainting	☐ Yes	□ No									
Since Yes No No Head Aches Yes No No Yes No No Yes No Yes No Yes No Yes No Ye	Fainting or dizziness	☐ Yes	□ No									
Vest No Nowledge, the above information is complete and correct. Understand that it am presponsible for all Charges whether or not paid by insurance. I amidor my dependently, have laurance correge with part of signatures or all insurance submissions. Nowledge, the above information: Understand that it am presponsible for all Charges whether or not paid by insurance. I amidorize to the sending payment for services and determining insurance benefits, if any, cherwise payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below. Nowledge the self-tending payment for services and determining insurance benefits, if any, cherwise payable for related services. This consent will end when my current treatment plan is completed or one year form the date signed below. Nowledge to the self-tending payment for services and determining insurance benefits, if any, cherwise payable for related services. This consent will end when my current treatment plan is completed or one year for the date self-tending payment for services and determining insurance benefits, or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year for the date services. This consent will end when my current treatment plan is completed or one year form the date signed below. Nowledge the protected Health Information: Understand that it may be redicted from the protected of the purpose of passing payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Now the protected Health Information: Understand that there may be a need to consult with other health care providers. I voluntarity authorize Describe in detail the Protected Health Information. Understand that there may be a lead of considered feedows. Now the payment of the services and used to					☐ Yes	□ No	·					
No Heppatitis Type Yes No No No No No No No N				Swollen Feet or Ankles	☐ Yes	□ No						
Have you ever had any complications Have you ever taken any of these medications Have you ever been hospitalized or do you have Bisphosphonates Yes No Godiene Yes No Godiene Yes No Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you ever been hospitalized or do you have Have you were been hospitalized or do you have Have you have Have you have Yes No Diet Medications Yes No Have you were been hospitalized or do you have Have you have Yes No Yes No				Swollen Neck Glands	☐ Yes	□ No						
Have you ever taken any of these medications Aspoin Are you allegist to: Aspoin Aspoin Yes No Blood Thiners Yes No Coumadin Yes No Blood Thiners Yes No Coumadin Yes No No No No No No No N				Thyroid Problems	☐ Yes	□ No	Tricumation ever	L 103	L 140			
Have you ever taken any complications New York New			□ NO				Are you allergic to:					
Sisphosphonates Yes No Coumadin Yes No No Coumadin Yes No No Coumadin Yes No No No Yes No No No No No No No N								☐ Yes	□ No			
Codematin Yes No Codeline Yes No Marfarin Yes No No Metals (i.e. gold) Yes No No Yes No Yes No No Yes Yes Yes No Yes Yes Yes Yes No Yes	following dental treatment?	☐ Yes	□ No									
Warfarin Ves No Diet Medications Ves No Pen-phen Ves N	If Yes, please describe						Codeine					
Place you ever been hospitalized or do you have any other health concerns? Yes No Port Health control pills? Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes							Ibuprofen	☐ Yes	□ No			
any other health concerns? Yes No Pren-phen Yes No Prendimin Yes No Redux Yes No Redux Yes No Prendimin Yes No			In an and				Latex	☐ Yes	□ No			
Fen-phen Yes No Pondimin Yes No No Pondimin Yes	•	•					Local Anesthesia	☐ Yes	□ No			
Women: Are you pregnant? Yes No Due date Yes Yes Yes No Due date Yes Yes	•						Metals (i.e. gold)	☐ Yes	□ No			
Redux Yes No Curvey Yes No Curvey Yes No Curvey Yes No Please PRINT all medications now taking: Signatures Signature Signa	If Yes, please describe						Penicillin	☐ Yes	□ No			
Due date Are you nursing? Yes No Please PRINT all medications now taking:												
Synthroid Yes No Please PRINT all medications now taking: Taking birth control pills? Yes No Please PRINT all medications now taking: Taking birth control pills? Yes No SIGNATURES To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with Name of Insurance Company(ies) and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all Charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of oblaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr	Women: Are you pregnant?	☐ Yes	□No	Levoxyl	☐ Yes	□ No	Other					
Please PRINT all medications now taking: Taking birth control pills? To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have Insurance coverage with Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all Charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr.				Synthroid	☐ Yes	□ No						
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have Insurance coverage with		П Уес	ПМо	Please PRINT all medication	s now tak	ing:						
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. Insurance Assignment: I certify that I, and/or my dependent(s), have Insurance coverage with												
Insurance Assignment: I certify that I, and/or my dependent(s), have Insurance coverage with	3			SIGNATURES								
Dr all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all Charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr to use and/or disclose my Protected Health Information (PHI) related to Name of Doctor Disclosing PHI The information will be used and/or disclosed for the purpose of	To the best of my knowledge, the above	information	n is complete	and correct. I understand that it is my	responsibility	to inform my	doctor if I, or my minor child, ever have	a change in	health.			
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your Protected Health Information to used and/or disclosed. Name of Doctor Receiving PHI This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no longer be protected by federal privacy regulations, I understand that I may revoke this authorization at any time by notifying. In writing, the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization. Signature of Patient, Parent, Guardian or Personal Representative Date Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient Patient Relationship to Patient	you are authorizing to be used and/o	or disclosed.	,. 1110	illionnation will be used and/or disclose	sa ioi tile pui		Describe in d each purpose for which you a	are authorizing				
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Doctor's Comments and update	Signature of Patient, Parent, Guardian or Personal Representative Date											
Doctor's Comments and update												
	Please prin	it name of P	atient, Paren	t, Guardian or Personal Representative			Relationship to Patie	 ent				
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	10	UU	1 5	Commen	13 6	iriu	upuule					

Date

Results ___ Signature _



5286 Iron Horse Parkway Suite A Dublin, Ca 94568 (925) 587-1584

Office Policy Statement

Welcome to our office. We are pleased that you have selected our office. We find that communication with our patients regarding our office policy assists us in providing the best service to you and helps avoid misunderstandings. Please sign at the bottom that you recognize and agree to these terms. Please feel free to ask us any questions.

Dental Insurance

We are happy to help you file the necessary forms to insure that you receive the full benefits of your policy; HOWEVER we can make no guarantee of any estimate coverage. Your co-payment is due on the date of services rendered. Your insurance policy is an agreement between you, your employer and your insurance company. We ask that all patients be responsible for services rendered in this office. Services provided must be paid for at the time of treatment. There is an interest rate charged of $1\frac{1}{2}$ % per month to any account that is 45 days past due.

Appointments

We respect your appointment time and take every effort to begin your treatment as scheduled. We request at least 48 hours notice to allow another patient to use the time that had been set aside for your visit. Failure to let us know of your cancellation 48 hours in advance will result in a \$50.00 charge per hour to you.

Returned checks and Collection action

If a check is returned to us for insufficient funds, a \$25.00 service fee charge will be applied to your account. IF you are forwarded to our collection agency, you will be responsible for all charges, including interest, late charge fees, collection fees, and attorney's fee.

Thank you for taking the time to read this policy statement.
I (we) have read, understand, and agree to the above policy.
Responsible Party/Patient:
Date:



Privacy Practices Acknowledgement

I received the Notice of Privacy Practices and I have been provided an opportunity to review it. Name ______ Birth Date _____ Date _____



Watermark Medical ARES Questionnaire PRINT IN CAPITAL LETTERS - STAY WITHIN THE BOX

Mode Pounds Age						APITAL LET	I E INC	- 01/	~ <i>i VVI</i>	111111	TITE BOX	. –			
Weight Feet	First Name	Middle Initial		le Initial	Last Name										
Neck Size													RISK F	oints.	
Height Feet Inches Neck Size Inches Neck Size Complete Date of Birth Day Year ID Number Optional		Pounds	3			Years			(Gender					
Height Month Day Year ID Number Score	Weight		Age				○ Male ○ Female			Female		Neck	Size		
Completely Fills In One Circle For Each QUESTION - Answer All QUESTIONS		Feet		Inches						Inches					
Date of Birth Month Day Year ID Number Score	Height					Neck Siz	e					L	-2101110	0 = 10.0	
Completely Fill In ONE CIRCLE FOR EACH QUESTION - ANSWER ALL QUESTIONS Have you been diagnosed or treated for any of the following conditions? Have you been diagnosed or treated for any of the following conditions? Heart disease															
Have you been diagnosed or treated for any of the following conditions? High blood pressure	Date of Birth	Month	Da	ıy	Year	ID Number		Optional					Score		
Have you been diagnosed or treated for any of the following conditions? High blood pressure															
Have you been diagnosed or treated for any of the following conditions? High blood pressure															
High blood pressure O Yes O No Stroke O Yes O No Depression O Yes O No Diabetes O Yes O No Depression O Yes O No Diabetes O Yes O No Sleep apnea O Yes O No O No Sleep apnea O Yes O No O No Nasal oxygen use O Yes O No O Nasolopays O Yes O No Nasal oxygen use O Yes O No O Nasolopays O Yes O No Nasal oxygen use O Yes O No O Nasolopays O Yes O No Morning Headaches O Yes O No No Nasolopays O Yes O No Morning Headaches O Yes O No O No Nasolopays O Yes O No Morning Headaches O Yes O No No Nasolopays O Yes O No Morning Headaches O Yes O No No Nasolopays O No No No Nasolopays O No No No No No No Nasolopays O No No No No No No No No No	COMPLETEL	Y FILL IN	ONE C	IRCL	LE FOR EAC	CH QUESTIC	ON - A	ANSW	ER ALI	L QUE	STIONS				
High blood pressure	Have you been diagr	nosed or treate	ed for an	y of th	e following cor	nditions?							Co-mor	bidities	
Heart disease	High blood pressu	ure	O Yes	;	O No	Stroke			0 '	Yes	O No		+1 for ea	ach Yes	
Lung disease	Heart disease		O Yes	;	O No	Depression			0 '	Yes	O No	L	respo	nise	
Lung disease						•									
Insomnia	21430100		- 100									_	<u>Score</u>		
Insomnia	Lung disease		O Yes	;	O No	Nasal oxygei	n use		0 '	Yes	O No				
Do not assign any points for these eight responses	9		O Yes	;	O No			ome	0,	Yes	O No				
Sleeping Medication O Yes O No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No No Pain Medication(e.g., woodn. Oxycorillin) O Yes O No							-							0	
Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try yo work out how they would have effected you. Use the following scale to mark the most appropriate box for each situation. 0 = would never doze												1	these	eight	
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and 11 or more (very high risk)