PURE DENTAL OF CAMARILLO
Exceptional care with a gentle touch

PATIENT INFORMATION

Patient Name _____ Date _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____ SSN _____

_____ Birthdate _____ Female ☐ Male ☐

Employed by _____ Work Phone _____

How did you hear about this Office? _____

Emergency Contact Name _____ Relationship _____ Phone _____

RESPONSIBLE INFORMATION

Dental Insurance _____ Group _____ Employer _____

Subscriber _____ Phone _____ SSN _____ Birthdate _____

MEDICAL HISTORY

I consider my health to be (please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? Please circle Y for yes or N for No.

Y	N	Abnormal Blood Pressure	Y	N	Herpes
Y	N	AIDS	Y	N	History of Drug Addiction
Y	N	Anemia	Y	N	History of Emotional or Nervous Disorders
Y	N	Arthritis	Y	N	Immune Suppressed Disorder
Y	N	Asthma	Y	N	Implants/Artificial Joints
Y	N	Cancer/Chemotherapy	Y	N	Infectious Mononucleosis (Mono)
Y	N	Congenital Heart Lesions	Y	N	Jaundice
Y	N	Diabetes	Y	N	Kidney Disease
Y	N	Epilepsy/Seizures	Y	N	Liver Disease
Y	N	Excessive Bleeding	Y	N	Prolonged Bleeding Disorder
Y	N	Excessive Urination and/or Thirst	Y	N	Radiation Treatment
Y	N	Fainting Spells	Y	N	Rheumatic Fever
Y	N	Glaucoma	Y	N	Sexually Transmitted/Venereal Disease
Y	N	Hay Fever	Y	N	Sinus Trouble
Y	N	Hearing Loss	Y	N	Stroke
Y	N	Heart Disease	Y	N	Tuberculosis or Lung Disease
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Tumor or Malignancy
Y	N	Hepatitis Type	Y	N	Ulcers
Y	N	Do you smoke or use tobacco	Y	N	I have consumed alcohol within the last 24hrs
Y	N	Have you ever taken Fen-Phen or Redux?			

Doctors Notes Only:

Women:

Y N Are you taking birth control medication?

Y N Are you or could you be pregnant?

Y N Are you nursing?

Y N Are you taking any medications, pills or drugs? _____

Y N Are you under a physician's care now? Name _____ Phone _____ Fax _____

Y N I have had major surgery: Year _____ Type of operation _____ Year _____ Type of operation _____

Y N Do you have any other medical problem or medical history NOT listed on this form? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Local Anesthetics ☐ Latex ☐ Metal ☐ Other _____

PATIENT INTERVIEW

What are your thoughts about going to the dentist? _____

What were your previous dental experiences like? _____

What dental health problems have you had in the past? _____

Do you experience frequent headaches, neck, or back pain? _____

What do you like/dislike about your smile? _____

What are your objectives regarding your dental health? ☐ Be Pain Free ☐ Healthy Gums ☐ Fresh Breath ☐ Straighter Teeth

☐ Bright/White Smile ☐ Keep your natural teeth for a life time ☐ Handle the problem correctly the first time ☐ Other _____

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above-named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

HIPPA PRIVACY RULE PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))
I _____ understand that as part of my healthcare, **Pure Dental of Camarillo** originates and maintains health records describing my health history, symptoms, examinations, diagnosis, test results, treatment and any plans for the future care and or treatment.
I am aware and acknowledge the **Notice of Privacy Practices** provided by **Pure Dental of Camarillo.** Upon request I may receive a copy of the **Notice of Privacy Practices.**

Patient Name Relationship

Signature Date

Parties to whom my Personal Health Information may be released:

Name Relationship

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charge directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. **I am aware there is a charge of $75.00 for any and all missed appointments without 48-hours' notice.**

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Patient's or Legal Guardian's/Representative's Signature Date