PATIENT REGISTRATION

Perry Silva DDS MD

(Mr., Mrs., Ms., Dr.) **First Name**_____ **M.I.**____ **Last Name**_____

Sex: ☐ Male ☐ Female **Date of Birth**_____ **Age**_____ **Soc. Sec #**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Tel. # (___) _____ **Business Tel**. # (__) _____ ext_____

Cell # (___) _____ **Email Address**_____

Employer_____ **Address**_____

Name of your Dentist(s)_____ **Orthodontist**_____

Name of your Physician(s) _____ **Phone** # (___) _____

Have you or a family member ever been a patient of our practice? ☐ Yes ☐ No Name_____
Year: _____ Procedure: _____

Whom may we thank for referring you to our practice? _____

Primary Dental Insurance Company
Employer_____
Bus. Address_____
Bus. Tel. #_____

Ins. Co. Name_____
Ins. Address_____
Ins. Tel. #_____
Group #_____

Subscriber Name_____
Relation to Patient_____
Sex: Male Female Date of Birth _____
Soc. Sec. #_____

Secondary Dental Insurance Company
Employer_____
Bus. Address_____
Bus. Tel. #_____

Ins. Co. Name_____
Ins. Address_____
Ins. Tel. #_____
Group #_____

Subscriber Name_____
Relation to Patient_____
Sex: Male Female Date of Birth _____
Soc. Sec. #_____

Information for primary guardian/person financially responsible (parent present)

Name:_____ Soc. Sec. #_____
Address_____ DOB:_____
City_____ State___ Zip_____ Home Tel. # (___) _____ Cell # (__) _____
Employer_____ Employer Tel. # (___) _____
Employer's Address_____
☐ Married ☐ Divorced ☐ Legally Separated ☐ Single

Emergency Contact Name:_____ **Telephone #** _____

I have read and answered all questions appropriately. I authorize treatment and I understand that I am responsible for payment of all services rendered to me. If needed, I authorize the use of this statement to obtain credit information.

Signature:_____ **Date**: _____
Person Financially Responsible

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Reason for Visit/Chief Dental Complaint:_____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? Y N
   If yes, please describe:
   _____
   _____
   _____
   _____
6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever, Rheumatic Heart Disease Y N
   - B. Congenital Heart Disease Y N
   - C. Cardiovascular Disease (heart attack, heart trouble, heart murmur, Coronary Artery Disease, Angina, high blood pressure, stroke, palpitations, heart surgery, Pacemaker) Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, shortness of breath, chest pain) Y N
   - E. Seizures, convulsions, Epilepsy, fainting or Dizziness Y N
   - F. Bleeding Disorder, Anemia, bleeding tendency, blood transfusion? Do you bruise easily Y N
   - G. Liver Disease (Jaundice, Hepatitis) Y N
   - H. HIV/AIDS Y N
   - I. Kidney Disease Y N
   - J. Diabetes Y N
   - K. Thyroid Disease (Goiter) Y N
   - L. Arthritis Y N
   - M. Stomach ulcers or Colitis Y N
   - N. Glaucoma Y N
   - O. Osteoporosis Y N
   - P. Implants placed anywhere in your body (Heart Valve, Pacemaker, hip, knee) Y N
   - Q. Radiation (X-ray) treatment for cancer Y N
   - R. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth Y N
   - S. Sinus or nasal problems Y N
   - T. Chronic or Acute Pain Disorder (Fibromyalgia, Neuralgia, facial pain, neck pain, back pain, etc.) Y N
   - Q. Any disease, drug, or transplant operation that has depressed your immune system Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics Y N
   - B. Anticoagulants (Blood Thinners) Y N
   - C. Aspirin, Motrin, Aleve, Ibuprofen Y N
   - D. High Blood Pressure medications Y N
   - E. Steroids (Cortisone, Prednisone, etc.) Y N
   - F. Tranquilizers Y N
   - G. Insulin or Oral Anti-Diabetic drugs Y N
   - H. Inderal, Nitroglycerin or other heart drug Y N
   - I. Are you taking or ***have you ever taken*** Bisphospho-nates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)? Y N

K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____
_____
_____
_____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia Y N
   - B. Penicillin or other antibiotics Y N
   - C. Sedatives, Barbiturates Y N
   - D. Aspirin or Ibuprofen Y N
   - E. Codeine or other pain killers Y N
   - F. Latex or Rubber products Y N
   - G. Metal of any kind Y N
   - H. Chemicals or jewelry (rash or sensitivity) Y N
   - I. Food products Y N
   - J. Other allergies or reactions? Or have you been advised not to take a medication? Please list Y N
     _____
9. Do you smoke or chew tobacco? Y N
   How much per day? _____
10. Is there any past history of alcohol or chemical dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with any previous dental treatment? Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
14. Do you wish to talk to the doctor privately about anything? Y N
15. Have you ever had a bone density scan? Y N
16. Do you take antibiotics before your dental appointments? Y N

Describe any "Yes" answer(s) regarding questions #10-16:
_____
_____
_____
_____

16. **FOR WOMEN ONLY**
    - A. Are you pregnant or **is there any** chance you might be pregnant? Y N
    - B. Are you nursing? Y N
    - C. **NOTE:** If you are using Oral Contraceptives, it is important that you understand that antibiotics (and other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use an alternate form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

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I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL AND COMPLETE HEALTH HISTORY TO ASSIST MY DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

_____ _____

Date Signature of Person Completing Health History Relation to Patient

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REVIEW OF HEALTH HISTORY
FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

_____

_____

Significant findings from questions or oral interview: _____

_____

_____

Dental Management Considerations: _____

_____

_____

Date: _____ Doctor's Signature: _____

Perry V. Silva, DDS, MD
880 Cass Street
Monterey, California 93940

Patient's Name: _____ Date: _____

Name of Person Responsible for Charges/Fees/Payments Due (if different from patient):

_____

Our office is a fee-for-service practice and therefore you are responsible for your bill in full.

Dr. Silva is not a provider for medical insurance PPOs, HMOs, DMOs, medicare or Medi-Cal-. We are providers for only a select group of dental insurances.

As a courtesy to our patients, we will contact your insurance company for a verbal pre-authorization or, if requested, send a written/electronic pre-authorization to your insurance carrier. In either case, we encourage you to contact your insurance carrier to discuss your benefits and eligibility. At the time of the procedure, you will be asked to pay an estimated partial payment, and we will bill your insurance carrier for services rendered. Any remaining balance is due from you after the insurance payment is received (please see truth in lending statement below).

Insurance coverage is a contract between you (the insured) and your insurance company. We are not a party to this contract**. If your insurance company does not pay the estimate balance due to eligibility, benefits, fee adjustments, or other reasons, you are responsible for the balance.** If there is any question concerning insurance coverage for the services performed or the amount paid by the insurance company, it is the insured's responsibility to contact the insurance company.

If your payment is made by check and the check is returned, a $25 return check fee will apply. Our office reserves the right to restrict payment options.

I understand the above information and agree that I am responsible for payment of all services rendered regardless of any estimate of insurance coverage given to me.

_____ _____
Signature of Person Financially Responsible Date