TIME 08:52 AM

DATE 5/7/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

Care Credit #

Emergency Contact

Emergency Contact #

Relationship to PT

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 7:09 PM

Gold Rush Dental Care

Date 5/5/2020

DENTAL QUESTIONNAIRE(Copy)

Patient Name:

Birth Date:

Date Created:

Your Dental History

When did you last visit the dentist?		Comment	
What was done at that time? (exam, cleaning, emergency, etc)		Comment	
Who was your previous dentist?		Comment	
Date of your most recent dental cleaning.		Comment	
Do you clean between your teeth and how?	○ Yes ○ No	If yes	
Do you have any specific problems with your teeth, gums, or mouth at this time?	○ Yes ○ No	If yes	

GUM DISEASE AND BONE LOSS

Do your gums bleed while brushing or flossing?	○ Yes ○ No		
Have you ever been treated for gum disease? (Deep cleanings, gum surgery)	○ Yes ○ No	If yes	
Do you have an unpleasant taste or odor in your teeth or mouth?	○ Yes ○ No	If yes	

RESTORATIVE DENTISTRY

Would you like to change anything about your smile?	○ Yes ○ No	If yes	
Do you have problems with teeth/fillings breaking?	○ Yes ○ No	If yes	
Are you interested in amalgam (mercury filling) removal?	○ Yes ○ No	If yes	
Are any teeth sensitive to hot, cold or sweets?	○ Yes ○ No	If yes	
Does food catch between your teeth?	○ Yes ○ No	If yes	
Do you feel your teeth are worn down?	○ Yes ○ No	If yes	

ORTHODONTIC CARE (BRACES, INVISALIGN)

Have you ever had orthodontic treatment?	○ Yes ○ No	If yes	
If Yes, do you have/wear retainers?	○ Yes ○ No	If yes	
If Yes, how old were you?	○ Yes ○ No	If yes	
Do you have jaw joint problems (TMJ)? (Clicking, popping of joints, pain)	○ Yes ○ No		
Do you feel you clench or grind your teeth?	○ Yes ○ No	If yes	
Do you have/wear a splint or night guard?	○ Yes ○ No	If yes	
Have you had head, neck or jaw injury?	○ Yes ○ No	If yes	
Do you have difficulty opeing your mouth wide?	○ Yes ○ No	If yes	

DENTAL IMPLANTS

Have you lost any teeth?	○ Yes ○ No	If yes	
Do you have dental implants?	○ Yes ○ No	If yes	
Would you like any missing teeth replaced?	○ Yes ○ No	If yes	

PARTIAL AND DENTURES

Do you wear dentures or partial dentures?	○ Yes ○ No	If yes	
Are your dentures or partial dentures loose?	○ Yes ○ No	If yes	
Do you have problems eating with them?	○ Yes ○ No	If yes	
Would you like any changes to your dentures or partial dentures?	○ Yes ○ No	If yes	

THE LODI DENTIST

David A Neal, DDS and Associates

THE LODI DENTIST

David A. Neal, DDS and Associates

1104 South Fairmont Avenue – Lodi, CA 95240 – (209)369-3657

FINANCIAL AGREEMENT FOR THE LODI DENTIST

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's overall health and quality of life. Financial considerations should not be an obstacle to obtaining this important care. To assist you in choosing the method of payment that is best for your situation, we have several financing options.

We accept cash, personal checks or credit cards (MC, Visa, AMEX and Discover). We are also partnered with Care Credit and Lending Point. This partnership makes it possible for lower interest as well as deferred interest financing. Unless financial arrangements are made in advance, fees are due and payable at the time treatment is rendered.

For our patients with dental insurance, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. Payment for your estimated portion is due and payable at the time treatment is rendered. The insurance relationship constitutes an agreement between the carrier and the insured. As such, we can make no guarantee of estimated coverage or payment. Because we cannot guarantee your exact insurance benefit payable, there may be a balance remaining after insurance payment has been received. Any remaining balance is due upon receipt of invoice.

I acknowledge that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also acknowledge that I am ultimately responsible for all charges incurred for dentistry performed upon myself or dependents in this dental office. If my insurance claim is not paid within 60 days of filing, the outstanding balance will be my responsibility.

Responsible Party Signature _____ Date _____

RESERVATION AGREEMENT

We assure you that we are 100% committed to providing a timely and quality service. We believe an equally important aspect of delivering exceptional dental care is your commitment to our reservation policy. We kindly request that you honor your scheduled appointment as a "reservation" because we reserve that time specifically for you and only you.

Should you need to change your reservation for any reason, we request you give our office a minimum of a 2 business day notice. If a reserved appointment is missed or changed without the 2 business day notice, you may be required to pay a $50 reservation fee in order to reserve your next appointment. We appreciate your understanding in this matter.

Responsible Party Signature _____ Date _____