Jean Francisco Braza, DDS
Family Dentistry & Orthodontics
Phone: 805-981-8880, Fax: 805-981-8007

PATIENT INFORMATION

(PLEASE PRINT)

PATIENT NAME

______________________ Birth Date ____________

Referred by ☐ Church Flier ☐ School Flier ☐ Phonebook ☐ Website/Internet ☐ Other

If patient is a minor, give parent's or guardian's name ____________ Relationship ____________

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

Address ____________ City ____________ State ______ Zip ______

SSN# ____________ Cell Phone# ____________ Home Phone# ____________

Employer ____________ Position ____________ Bus Phone# ____________

Bus Address ____________ City ____________ State ______ Zip ______

Emergency contact name ____________ Phone# ____________

Nearest relative address ____________ Phone# ____________

Purpose of this appointment ____________ E-mail: ____________

SPOUSE / PARENT NAME

______________________ Birthdate ____________

Employer ____________ Position ____________ Bus Phone# ____________

Bus Address ____________ City ____________ State ______ Zip ______

SSN# ____________ Cell Phone# ____________ Home Phone# ____________

INSURANCE INFORMATION

Do you have insurance? ☐ YES ☐ NO If YES, complete the following

Name of Insured ____________ SSN# ____________ Relationship ____________

Birth Date ____________ Insurance Co. ____________ Group # ____________

Is patient covered by other insurance? ☐ YES ☐ NO If YES, complete the following

Name of Insured ____________ SSN# ____________ Relationship ____________

Birth Date ____________ Insurance Co. ____________ Group # ____________

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. 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, the dental office cannot render services on the assumption that charges will be paid by an insurance company. A service charge of 1 ½% per month (18% annum), but in no event more than the maximum allowable permissible under state law, will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor or his/her staff, I agree to pay therefore, the reasonable value of said services to Doctors, or his/her assignee at the time said services are rendered to me, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach, of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further 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 cover all costs incurred including reasonable attorneys' fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signed ______________________ Date ____________

PLEASE COMPLETE BOTH SIDES

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HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care. Please answer all questions.

Circle or check YES or NO where applicable.

MEDICAL HISTORY

1. Are you now under the care of a physician? ☐Yes ☐No
   If yes, what's your doctor's name and phone number? __________
   What is the condition being treated? __________
2. Have you ever been hospitalized or had any serious illness or operation? ☐Yes ☐No
   If yes, please describe __________
3. Are you taking medications? ☐Yes ☐No
   If yes, what medications? __________
4. Have you ever been pre-medicated with antibiotics for your dental treatment? ☐Yes ☐No
5. Are you sensitive or allergic to: ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other (please list): __________
6. Do you have or have you had any of the following? (check or circle each one)

AIDS	Cerebral Palsy	Heart condition	Kidney Disease	Sickle cell disease
Allergies/Hives	Chemotherapy	Heart murmur	Leukemia	Sinus Trouble
Arthritis	Cold Sores	Hemophilia	Liver Disease	Stomach ulcers
Artificial Prosthesis	Cortisone medicine	Hepatitis A,B, or C	Mental disorder	Stroke
Asthma	Diabetes	Herpes	Mitral Valve Prolapse	Swallowing problem
Bleed easily	Emphysema	High blood pressure	Nervous disorder	Thyroid disease
Blood Disease	Epilepsy / Seizure	HIV Positive	Psychiatric Tx	Tuberculosis
Blood Transfusion	Fainting spells	Jaundice	Radiation Tx	Tumors or growths
Bruise easily	Glaucoma	Jaw pain	Respiratory disease	Venereal Disease
Cancer	Head injury	Joint replacement	Rheumatic Fever	Other:

7. Are you taking any recreational drugs? ☐Yes ☐No
   Any drug addiction. Please explain: __________
8. Are you taking any blood thinner medication? ☐ Coumadin ☐ Plavix ☐ Other: ☐Yes ☐No
9. Have you taken FEN-PHEN, REDUX or PONDIMIN? ☐Yes ☐No
10. Do you wear a cardiac pacemaker, or have you had heart surgery? (when) ☐Yes ☐No
11. Do you have any disease, condition or problem not listed that you think I should know about? ☐Yes ☐No
    Please explain: __________
12. (Women) Are you pregnant? If so, how many months? ☐Yes ☐No
13. (Women) Do you have any problems associated with your menstrual period? ☐Yes ☐No
14. (Women) Do you take birth control pills? ☐Yes ☐No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ☐Yes ☐No
2. Have you ever had any unfavorable reaction to a local anesthetic? ☐Yes ☐No
3. Have you ever had any serious trouble associated with any previous dental treatment? ☐Yes ☐No
   If so, explain: __________
4. How long since your last full-mouth X-rays? __________
5. How long since your last Dental Treatment? __________
6. Does dental treatment make you nervous? ☐Yes ☐No
   If yes, check one: ☐ Slightly ☐ Moderately ☐ Extremely
7. Would you desire to be pre-sedated? ☐Yes ☐No

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or if my medications change, I will, without fail, inform my doctor at my next appointment.

Date ______ Signature __________

Year 2 – Changes in health? YES NO
Date ______ Signature __________

Year 3 – Changes in health? YES NO
Date ______ Signature __________

DO NOT WRITE IN THIS SPACE

Reviewed by		Year 1	Year 2	Year 3
	Date			
Year 1	BP			
	Pulse			
Year 2	Temp			
Year 3	By			

Health questionnaire must be updated every year! Consent for treatment: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this health history form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs. I also acknowledge that I have been provided by display a copy of the DENTAL MATERIAL FACT SHEET adopted October 17, 2001, as well as a copy of the "Notice of Privacy Practices" taking effect on April 14, 2003, copies of which will be given to me upon my request. All services are rendered and accepted under the terms and conditions printed on the reverse hereof.

Signed: __________ Date: __________

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to patient: __________

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