VALLEY CENTER SMILES
Greg Carlson, D.D.S.

PATIENT INFORMATION

First Name_____(M.I.)_____Last_____

Preferred Name_____Birth Date_____SS#_____-_____-_____

Mailing Address_____City/State/Zip_____

Home Phone(____)_____Work(____)_____Cell(____)_____

Email _____Driver License & State_____

Employer_____Occupation_____

Person Responsible for Paying Bill ☐ Check if same as that listed for patient information

First Name_____(M.I.)_____Last_____

Preferred Name_____Birth Date_____SS#_____-_____-_____

Mailing Address_____City/State/Zip_____

Home Phone(____)_____Work(____)_____Cell(____)_____

Email _____Driver License & State_____

Employer_____Occupation_____

Insurance Information

Primary Ins. Co_____Phone(____)_____

Insured Name_____Employer_____

ID#_____Group #: _____SS#_____-_____-_____

Secondary Ins. Co_____Phone(____)_____

Insured Name_____Employer_____

ID#_____Group #: _____SS#_____-_____-_____

Emergency Contact Information – ***Mandatory (Please provide all information you know)***

First Name_____(M.I.)_____Last_____

Relationship _____Email_____

Home Phone(____)_____Work(____)_____Cell(____)_____

Street Address_____City/State/Zip_____

Referrals helps us grow. Is there anyone we can thank for your visit today?_____

VALLEY CENTER SMILES
Greg Carlson, D.D.S.

PATIENT HISTORY

First Name_____(M.I.)_____Last_____

What would you like us to do today? _____

Are you nervous or concerned about treatment?_____Are you having discomfort today?_____

How long since last dental visit_____What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Do you:

☐ Clench or grind your teeth	☐ Chew only on one side of mouth
☐ Have frequent headaches	☐ Bleed when you floss or brush
☐ Have dry mouth	☐ Smoke or use chewing tobacco
☐ Have any missing teeth – Replaced? ☐ Y ☐ N	☐ Want to hear about advances in cosmetic dentistry
☐ Have teeth sensitive to:	☐ Use controlled substances
☐ Hot ☐ Cold ☐ Sweets ☐ Pressure	

Check all that apply: **If checked, please explain in space provided.**

☐ I am currently under a physician's care.

☐ I have been hospitalized or had a major operation.

☐ I have suffered a serious head or neck injury.

☐ I am taking medications, pills or other drugs.

☐ I take or have taken Phen-Fen or Redux.

☐ I am on a special diet.

☐ I am pregnant, trying to get pregnant, taking oral contraceptives, and/or nursing.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be hazardous to my (or the patient's) health. It is my responsibility to inform Valley Center Smiles of any changes in medical and/or dental status as well as any other change that may relate to my care at Valley Center Smiles.

Print Name of Patient_____

Signature_____ Date_____

If signing on behalf of a minor, please print your name below:

_____ Relationship:_____

VALLEY CENTER SMILES
Greg Carlson, D.D.S.

MEDICAL HISTORY

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other – Please explain:_____

Do you have, or have you had, any of the following?

☐AIDS/HIV Positive	☐Chest Pains	☐Frequent Headaches	☐Irregular Heartbeat	☐Scarlet Fever
☐Alzheimer's	☐Cold Sores/Fever Blisters	☐Genital Herpes	☐Kidney Problems	☐Sexually Transmitted Disease
☐Anaphylaxis	☐Congenital Heart Disorder	☐Glaucoma	☐Leukemia	☐Shingles
☐Anemia	☐Convulsions	☐Hay Fever	☐Liver Disease	☐Sickle Cell Disease
☐Angina	☐Cortisone Medicine	☐Heart Attack/Failure	☐Low Blood Pressure	☐Sinus Trouble
☐Arthritis/Gout	☐Diabetes	☐Heart Murmur	☐Lung Disease	☐Spina Bifida
☐Artificial Heart Valve	☐Drug Addiction	☐Heart Pace Maker	☐Mitral Valve Prolapse	☐Stomach/Intestinal Disease
☐Artificial Joint	☐Easily Winded	☐Heart Trouble/Disease	☐Pain in Joints	☐Stroke
☐Asthma	☐Emphysema	☐Hemophilia	☐Parathyroid Disease	☐Swelling of Limbs
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Psychiatric Care	☐Thyroid Disease
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Radiation Treatments	☐Tonsilitis
☐Breathing Problem	☐Excessive Thirst	☐Herpes	☐Recent Weight Loss	☐Tuberculosis
☐Bruise Easily	☐Fainting Spells/Dizziness	☐High Blood Pressure	☐Renal Dialysis	☐Tumors or Growths
☐Cancer	☐Frequent Cough	☐Hives or Rash	☐Rheumatic Fever	☐Ulcers
☐Chemotherapy	☐Frequent Diarrhea	☐Hypoglycemia	☐Rheumatism	☐Yellow Jaundice

☐Serious illness not listed above. Please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be hazardous to my (or the patient's) health. It is my responsibility to inform Valley Center Smiles of any changes in medical and/or dental status as well as any other change that may relate to my care at Valley Center Smiles.

Print Name of Patient_____

Signature_____ Date_____

If signing on behalf of a minor, please print your name below:

_____ Relationship:_____

VALLEY CENTER SMILES
Greg Carlson, D.D.S.

Consent to Release Information & Agreement to Pay

I authorize Valley Center Smiles to release medical and/or dental information for insurance purposes concerning treatment of the patient named below. I authorize payment of any insurance benefits to be paid directly to Valley Center Smiles. I also agree to pay Valley Center Smiles any fees not covered by those insurance benefits.

Print Name of Patient_____

Signature_____ Date_____

If signing on behalf of a minor, please print your name below:

_____ Relationship:_____

Acknowledgment of HIPAA Policy

I acknowledge that Valley Center Smiles "Notice of Privacy Practices" has been made available to me. I am aware that I may obtain a copy of the policy at any time.

Print Name of Patient_____

Signature_____ Date_____

If signing on behalf of a minor, please print your name below:

_____ Relationship:_____

VALLEY CENTER SMILES
Greg Carlson, D.D.S.

OFFICE POLICIES

Welcome to Valley Center Smiles. We are honored that you've chosen us as your dental care provider. The policies stated below have been put in place to ensure that we can provide the best service to all our patients. We look forward to working with you!

Payment Policy: Payment for all treatment is due on the date of service. If you have dental insurance, Valley Center Smiles will work with you and your insurer to determine your coverage. We will submit a bill to your insurer based on the portion of your treatment covered by your plan. The difference between our fee and what is covered by your insurance will be due on the date of service.

A 5% discount will be given for cash/check payments and a 3% discount will be given for credit card payments made upon completion of major treatments (crowns, bridges, veneers, dentures, and implants).

Missed Appointments: Your appointment time is reserved just for you. If you are unable to keep your appointment, please let us know at least 24 hours in advance so that we may schedule a new time for you. If you need to reschedule an appointment set for a Monday, please call our office before noon on Friday. Our office depends on our patients. As a result, a $50 fee will be charged to a patient who does not reschedule or cancel an appointment within 24 hours of the appointment time. Patients who miss two or more appointments without following this policy may be dismissed from the practice.

Late Appointments: If you are late for your appointment time by more than 10 minutes, we may need to reschedule your visit. The second time a patient is late for an appointment a $50 late fee will be charged. A patient that is consistently late for appointments may be dismissed from the practice.

Treatment of Minors: Consent for extractions or root canals on a person under age 18 must be obtained in writing from a parent or legal guardian prior to treatment. A parent or legal guardian must be present in the office when a child under the age of 16 is being treated. Minors aged 16 and over may be treated for routine procedures without a parent or legal guardian present.

I have read and understand the above stated Office Policies.

Print Name of Patient_____

Signature_____ Date_____

If signing on behalf of a minor, please print your name below:

_____ Relationship:_____