Sorrento Valley Perfect Smile
Dental Group of Alek Zand DDS
Health Questionnaire

Date:________________

Patient full name: _______________________ Name you preferred to be called: _____________________
Home phone: ______________ Cell phone: ______________ Work phone______________________
Home address: ___________________________________City: _____________State: ___ Zip: ___________
Email address:__________________________
Date of birth_______________ SS No. __________________ Marital status: Married___ Single___
Emergency contact name/ relationship to you:______________________________/_____________________
Emergency contact#:___________________________ How did you hear about us?_____________________

Occupation: _____________________ Employer: _________________________ How long: ____________
Business address: _________________________________ City: _____________State: ____ Zip: _________

Primary insurance holder: ___________________ Relationship to patient: Self ___ Spouse___ Parent___
Primary insurance holder date of birth: ______________ Primary insurance holder SSN:________________
Dental insurance carrier ___________________ Subscriber ID number______________________
Group number_________________________ Group plan name _________________________

Dental History

1. When did you have your last dental examination? __________________Dentist________________
   Was restorative treatment recommended? ____
   What treatment was recommended? ____
   Was treatment completed? ______ If not, why? ____
2. What problem have you had with your teeth? ____
3. Are you please with the appearance of your teeth? ______________________________________
4. Would you like your teeth to be whiter? ____
5. Is there any specific treatment you would like to discuss? _________________________________
6. What do you feel the condition of your mouth is now? ___________________________________

General Health Questionnaire

1. Are you being treated by a physician at this time? Yes _____ No_____
   For what? ____
2. Have you ever had any complication following dental treatment? Yes _____ No_____
   If yes, please explain: ____
3. Have you ever taken cortico steroids? ____ When? __________ For how long? _______________
   For what? ____
4. Have you ever taken anti-coagulants (blood thinners)? ______________________________
5. Are you allergic to, or have you ever been allergic to aspirin, codeine, novacaine, Demerol, Penicillin, barbituates, sulfa drugs, iodine, or any other drugs? ______________________________
   If yes, please explain: ____
6. Are you taking any medication or substances? ____ If yes, please list: ________________________

7. Have you ever noticed any lumps or swelling in your mouth, head, or neck area? ____________
8. Have you ever had any major surgery or illnesses? ____________________________________

9. Women: are you
   Pregnant/ Trying to get pregnant? Yes _____ No____ Nursing? Yes _____ No____
   Taking Oral Contraceptive? Yes _____ No____
10. Please select yes or no:

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______________________________

Comments:____
____
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:_______________________ Date:__________________

Assignment authorization/Release of Information

I the undersigned, hereby authorize Sorrento Valley Perfect Smile Dental Group of Alek Zand DDS to apply for benefits on my behalf for services rendered to me or my dependents. I request payment from my insurance carrier be made directly to Dr. Zand or Sorrento Valley Perfect Smile Dental Group of Alek Zand DDS, and in case where the carrier has made payments directly to me, I'll return funds to Dr. Zand. I certify that the information on this form is correct and further authorize its release to all parties involved in my care and care of my dependents.

I agree that I have been offered access to Sorrento Valley Perfect Smile Dental Group of Alek Zand DDS's NOTICE OF PRIVACY PRACTICE (HIPPA) and FINANCIAL policies. Written copies are available at my request. I authorize Sorrento Valley Perfect Smile Dental Group of Alek Zand DDS to discuss my medical/dental information with the following people/ list their relationship to me:

____
____

Signature of Patient, Parent, or Guardian:_______________________ Date:__________________

Sorrento Valley Perfect Smile
Dental Group of Alek Zand DDS
Financial Policy

The following is a statement of our financial policy. Which, we require you to read and sign prior to any treatment. As a courtesy we accept assignment of benefits. However, we cannot bill your insurance unless you supply all insurance information. Your insurance is a contract between you and your insurance company. We are not a party to that contract. The balance is your responsibility whether your insurance company pays or not. All treatment estimations are only an “estimations". We work as close as possible with your insurance to give the best estimate possible.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance, this office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account, however all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

In consideration for the professional services rendered to the patient by this practice, patient agrees to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. Patient further agrees that the charges for services shall be billed unless objected by patient in writing, within the time payment is due. In addition patient grants permission to Sorrento Valley Perfect Smile or their assignee, to telephone him/her to discuss matters related to this form.

We understand that unplanned issues can come up and you may need to cancel your appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least two business days in advance. Our doctors and hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If we don’t receive a call at least two business days before your appointment, there will be a charge of $50 per cleaning appointment and $100/hr for doctor appointment.

Thank you for being a valued patient and for your understanding and corporation as we institute this policy.

Name:______________________________ Sign:_______________________________

Date:______________________________