

Welcome to ACCU Dental

1171 Homestead Rd, #175, Santa Clara, CA 95050 | 730 Story Rd, #5, San Jose CA 95122

Thank You for choosing our office for your dental care. We strive to offer the highest quality dental care.

Today's Date _____

Patient Information

Patient Name _____ Date of birth _____
Male Female Single Married Divorced Widowed
Home Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security # _____ Driver's License # _____
Name of Nearest Relative (Not living with you) _____
Relationship _____ Relative's Phone Number _____
Who should we thank for referring you? (or mention referral source) _____
Responsible Party (if patient is a minor) _____
Student? Full Time Part Time School _____ Location _____

Insurance Information

Name of the Insured _____ Date of birth _____
Billing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security # _____ Driver's License # _____
Employer _____ Employment Start Date _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Local # _____
Insurance Co Address _____ City _____ State _____ Zip _____
Insurance Coverage (check all that apply) Self Spouse Children Other(s) _____
Relationship if "Others" is checked above _____

Consent: The undersigned hereby authorizes the doctor or qualified personnel to take radiographs (X-Rays), study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis for the purpose of dental treatment and care. I also authorize the doctor to perform any and all treatments and therapy and prescribe medications that may be needed for dental care for the patient named above. I further authorize and consent that the doctor may choose and employ such assistance as he/she deems fit. I also understand that the anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless an extended payment plan is arranged with the business office. I understand that a credit check will be done, if I elect not to pay at the time service is rendered.

Insurance note: The office is happy to work with the patients for paperwork regarding dental insurance claims. We ask you to read your dental insurance policy to be sure that you are fully aware of any limitations of the benefits provided. The fees we charge to those who are insured are our usual and customary fees. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the benefits coverage of procedure types and fees. We cannot render services on the assumption that the charges will be paid by the insurance company. We ask that you look upon your insurance realistically as a method which reimburses you for dental expenses partially or fully depending on the treatment received in this office. We will be pleased to complete all forms pertaining to your claim, and send them promptly to your insurance carrier, to help you obtain the reimbursement you are entitled to receive.

Missed Appointment Policy: In order to properly care for you and your family, we provide staff and facilities based on appointment scheduled by our patients. At least twenty four hour notification is required if you are unable to keep your scheduled appointment. When patients fail (an appointment) or do not provide adequate notification to us to reserve the time for another patient in need of treatment, we must still meet our financial obligations in order to maintain staff charges and overheads. The charge for a missed appointment is prorated at the rate of fifty dollars for every one hour of missed appointment. Thank you for your cooperation.

Signature _____ Date _____ Relationship to patient _____

Health Questionnaire

In order for a doctor to thoroughly diagnose any condition, we must have accurate data so that we may give personal attention to each individual. This information is confidential. Thank You.

Dental History

Reason for Today's visit _____ Date of last Dental Care _____
Former Dentist _____ Date of last Dental X-Rays _____
Former Dentist Address _____ City _____ State _____ Zip _____
Former Dentist Phone Number _____ How long since you last visited a dentist? _____
How often do you brush? _____ How often do you floss? _____
Have you ever had a local anesthetic (Novocaine, etc)? Yes No
Have you ever had adverse reaction to a local anesthetic? Yes No
Have you had any serious trouble associated with previous dental treatment? Yes No
If Yes, What? _____
Do you use tobacco? Yes No If Yes, What Type? Cigarettes Cigar Pipe Chewing
Does dental treatment make you nervous? No slightly Moderately Extremely
Check all that apply:
 Bad breath Grinding Teeth Sensitivity to hot
 Bleeding gums Loose teeth or broken fillings Sensitivity to sweets
 Clicking or popping jaw Periodontal treatment Sensitivity when biting
 Food collection between teeth Sensitivity to cold Sores or growths in your mouth

Medical History

Physician's Name _____ Phone# _____
Physician's Address _____ City _____ Zip _____
Are you in good health? Yes No
Date of last physical examination? _____ Any Current treatments? _____
Have you ever had a serious illness or operation? Yes No If yes, what? _____
Have you been hospitalized in the last 5 years? If Yes, why? _____
Are you taking any drug or medicine? Yes No If yes, What? _____ Dosage _____
Are you sensitive or allergic to any drug? Yes No If yes, which ones? _____
Have you ever had a blood transfusion? Yes No If, yes, give approximate dates? _____
Have you ever taken any group of drugs referred to as "fen-phen"? These include combinations of Lonimin, Adipex, Fastin (Phentermine brands), Pondimin (fenfluramine) and Redux (defenfluramine). Yes No
Women, are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Warning: Antibiotics may alter the effectiveness of birth control pills

Check if you have or had any of the following? Check all that apply:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Feet Area
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease

Do you have any disease, condition or problems not listed? If yes, describe _____

Signature

To the best of my knowledge, the information is complete and correct. I understand that it is my responsibility to inform my doctor, if or my minor child, ever have a **change in health**

Signature of Patient, Guardian or Personal Representative

Date

Please Print name the Signature of Patient, Guardian or Personal Representative

Relationship to Patient