WelCome

We welcome you to Valley Alder Family Dentistry. We appreciate the trust placed on us to provide dental services. To help you service better, please complete the following information.

Chart # _____ Office Location _____ Date _____

Patient Information

First Name: _____ Middle Int. ____ Last Name: _____ Date of Birth: ____/____/____
Home Address: _____ Apt # _____ City _____ State _____ Zip _____
Home Phone Number: ( ) _____ Cellular Phone Number: ( ) _____
E-Mail Address: _____ DL # _____ SSN: _____- _____ - _____
Gender: □ Male □ Female □ Single □ Married □ Widowed □ Divorced □ Minor
Preferred contact method: □ Home # □ Cellular # □ Email □ Text Message □ Other _____
Employer: _____ Position: _____
Employer Address: _____ Employer's Phone Number: ( ) _____
In Case of Emergency contact: (name) _____ Phone #: ( ) _____ Relationship: _____

Payment Method: □ Cash □ Credit □ Insurance □ Medi-Cal □ Other _____

Responsible Party – If Different Than Above

Name: _____ Relationship: _____ Date of Birth: _____ SSN: _____

Insurance Information

Primary Dental Insurance Name: _____ Subscriber's Name: _____
Patient's Relationship: □ self □ spouse □ child □ other Subscriber's DOB: _____
Policy # _____ SSN: _____ Group #: _____

Secondary Dental Insurance Name: _____ Subscriber's Name: _____
Patient's Relationship: □ self □ spouse □ child □ other Subscriber's DOB: _____
Policy # _____ SSN: _____ Group #: _____

Personal References

First Name: _____ Middle Int. ____ Last Name: _____
Home Phone #: ( ) _____ Home Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____

First Name: _____ Middle Int. ____ Last Name: _____
Home Phone #: ( ) _____ Home Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____

Dental Information

Previous Dentist's Name: _____ Address: _____
Dentist's Phone #: _____ Date of last visit: _____ Reason for today's visit: _____
Referred to us by: _____
Are you happy with the overall appearance of your teeth? _____
Is there any aspect of your teeth appearance you want to change? _____
Are you interested in teeth whitening? _____

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctor's assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.

I am aware that by signing below I certify that all information is complete and correct. Dr Alpesh Patel, D.D.S., may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for Dr. Alpesh Patel, D.D.S. to verify credit history.

_____ _____
Signature of Patient Signature of Responsible Party

HEALTH HISTORY

Date: ____/____/____ Patient name: _____ Chart#: _____
Date of Birth: ____/____/____ SEX: M / F Height: _____ Weight in LBS. _____
Physician: _____ Office Phone: _____ Date of last exam: _____
In case of emergency, contact: _____ Phone #: ( ) _____ Relationship: _____

INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and be kept confidential.

1. Are you under any medical treatment now?..... Yes or No
2. Have you ever been hospitalized for any surgical operation or serious illness within last 5 years?..... Yes or No
   If yes please explain: ……
3. Are you taking any medication(s) including non-prescription medication?..... Yes or No
   If yes, please list your medication(s) ……
4. Do you use tobacco? …… Yes or No
5. Have you ever taken Redux® Fan Phen? …….... Yes or No
6. Do you use controlled substances? …….. Yes or No
7. Are you wearing contact lenses? ……. Yes or No
8. Do you have or had any of the following? Please Circle Y for yes and N for No)

High Blood Pressure	Y N	Low Blood Pressure	Y N	Chest Pain	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Heart Disease	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Heart Trouble	Y N	Angina	Y N	Mitral Valve Prolapse	Y N
Fainting/Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Easily Winded	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy/Convulsions	Y N	Cancer	Y N	Recent Weight Loss	Y N
Leukemia	Y N	Arthritis	Y N	Respiratory problems	Y N
Diabetes	Y N	Joint replacement/Implant	Y N	Swollen Ankles	Y N
Kidney Disease	Y N	Hepatitis/Jaundice	Y N	Liver Disease	Y N
AIDS or HIV infection	Y N	Stomach troubles/Ulcer	Y N	Hay Fever/Allergies	Y N
Thyroid problem	Y N	Sexually transmitted Disease	Y N	Sinus trouble	Y N
Hives or skin rash	Y N	Herpes	Y N	Sensitive teeth	Y N
Jaw click or pop	Y N	Clench or teeth grinding	Y N	Frequent Headache	Y N
Neck ache	Y N	Shoulder ache	Y N	Other _____	
Abnormal bleeding with previous extractions, surgery or trauma			Y N		
Have you had serious trouble with previous dental treatment			Y N	if yes, explain _____	

9. Are you allergic to or have you had any reactions to the following?

Local Anesthetics (e.g. Novocain)	Y N	Aspirin	Y N	Sedatives	Y N
Penicillin or any other antibiotics	Y N	Any Metals	Y N	Latex Rubber/ Power	Y N
Sulfa Drugs	Y N	Iodine	Y N	Barbiturates, sedatives, sleeping pills	Y N
Codeine or other narcotics	Y N	Other: _____			Y N

10. Woman ONLY:

Are you pregnant or think you may be pregnant?	Y N	Are you Nursing?	Y N
Are you taking any oral contraceptives?	Y N		

FOLLOW UP to Medical History by Dentist Only:_____

_____

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF PATIENT OR GUARDIAN (if patient is a minor) x_____ DATE: _____
SIGNATURE OF DENTIST x _____ DATE: _____

	DATE	COMMENTS	DR. SIGNATURE	PATIENT SIGNATURE
UPDATE				
UPDATE				
UPDATE				

HIPAA PRIVACY RULE RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM
DR. ALPESH PATEL, D.D.S.

Acknowledgement of receipt of Information Practices Notice (164.520(a))

I, _____ (Patient Name) understand that as part of my health care, Dr. Alpesh Patel, D.D.S., Bloomington, CA. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Dr. Alpesh Patel office in Bloomington, Ca. Notice of Privacy Practice provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Dr. Alpesh Patel's office for Notice of Privacy Practices prior to signing this acknowledgement.
- That Dr. Alpesh Patel in Bloomington, CA reserves the right to change their Notice of Privacy Practices.
- Prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested.

Print Name of Individual or Legal Representative Witness: _____ Date: _____

Signature of Individual or Legal Representative Witness: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Practices, but it could not be obtained because:

- Individual refused to sign ☐ **Y** ☐ **N**
- Communication barrier prohibited obtaining the acknowledgement ☐ **Y** ☐ **N**
- An emergency situation prevented us from obtaining acknowledgement ☐ **Y** ☐ **N**
- Other (please specify) ___

_____ _____

PRIVACY OFFICIAL DATE

HIPAA Privacy Rule of Patient Authorization Agreement
DR. ALPESH PATEL, D.D.S.

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508(a))

I, _____ (Patient Name) understand that as part of my health care, Dr. Alpesh Patel's office originates and maintains health records describing my health, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A total for routine health care operations such as assessing quality and reviewing the competence of health care professionals I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosure.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the Right to review Dr. Alpesh Patel's office in Bloomington, CA a notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for treatment or Healthcare Operations (164.506(a))

I understand that:

- I have the right to review Dr. Alpesh Patel's office in Bloomington, CA Notice of Information practices prior to signing this consent;
- That Dr. Alpesh Patel's office in Bloomington, CA. reserves the right to change the notice and practices prior to implementation will mail a copy of any revised notice to the address I have provide if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Alpesh Patel, D.D.S. is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Dr. Alpesh Patel's office in Bloomington, CA. has already taken action in reliance thereon.

Print Name of Patient or Legal Representative Witness: _____ Date: _____

Signature of Patient or Legal Representative Witness: _____ Date: _____

DR. ALPESH PATEL, D.D.S.
17644 VALLEY BLVD. UNIT 1
BLOOMINGTON, CA 92316
(909) 877-0650

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIAL FACT SHEET

I, _____, acknowledge I have received
Patient Name
from DR. ALPESH PATEL, D.D.S. a copy of the Dental Materials Fact

Sheet as required by the Law of Dental Board of California.

_____ _____
Patient Signature Date