Lambing Dental Corp.
1443 Leimert Blvd.
Oakland, California 94602
(510) 482-5300

Name(Mr / Ms / Mrs) _____ Birth date _____ SS# _____

Home Address _____
city state zip

Home Phone _____ Work Phone _____

Employer _____ Occupation _____ How long _____
(if student, name and address of school) at present job?

Employer Address _____
city state zip

Spouses Name _____ Employer _____

Spouses work address _____ work phone _____

Patient Ethnicity (optional) - ☐Caucasian, ☐African-American, ☐Latino(a), ☐Asian/Pacific Islander, ☐Native American, ☐Other

WHOM MAY WE THANK FOR REFERRING YOU TO US?

☐Friend, ☐Relative, ☐Physician, ☐Dentist, ☐Student, ☐Physician, ☐Other _____

☐Yellow Pages, ☐Newspaper, ☐Other Media, ☐Fair or screening, ☐Informational Presentation

If referred by an individual, name: _____ Phone _____

PRIMARY INSURANCE: Name of subscriber: _____
Relation of subscriber to patient

Employer: _____

Name of insurance co: _____ Social Security # of subscriber _____

Address of ins. co.: _____
city state zip

Phone # of ins. co. _____ Group # _____ Birth date of subscriber _____

SECONDARY INSURANCE: Name of subscriber: _____ Employer: _____

Name of insurance co: _____ Social Security # of subscriber _____

Address of ins. co.: _____
city state zip

Phone # of ins. co. _____ Group # _____ Birth date of subscriber _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY:

Name _____ Phone _____

Address _____
city state zip

WHO IS FINANCIALLY RESPONSIBLE FOR YOUR BILL? (if different than patient - name of responsible person, not insurance co.)

Name _____ Phone _____

Address _____
city state zip

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any changes in the above information.

Signature _____ Date _____

DENTAL APPOINTMENTS, FINANCIAL ARRANGEMENTS, AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment and appointment arrangements.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our office manager. We accept cash, checks, MasterCard, Visa, and Discover cards. We will be happy to process your insurance claim form for you.

For your convenience we can set up a contract that will allow you to pay for your dental care over a period of three months in some circumstances. We have a unique "Dental Credit Card" called CareFund which allows low monthly payments over the duration of 6 to 12 months.

Retumed checks are subject to a $20.00 fee. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. After 2 missed appointments, or appointments changed without adequate notice, we may ask you to find another source of dental care so we may offer appointments to other patients who desire to be seen.

We will gladly discuss your proposed treatment and ,to be sure that everything is understood, answer any questions relating to your insurance. You must realize, however, that:

1. If you have dental insurance, it is a contract between you, your employer, and the insurance company. We are not party to that contract.

2. Most companies pay a percentage of our accepeted fees. The percentage may vary by the type of procedure. Other companies reimburse based on a percentage of an arbitrary "schedule" of fees, which bears no relationship to the current standard cost in this area.

3. Not all services are a covered benefit in all insurance contracts. Some insurance companies select certain services they will not cover.

4. We will be happy to work with you to find out what insurance benefits your employer and insurance plan provides. We do not charge for this service.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask our office manager. We are here to help you.

_____ _____

Signed Date

MetLife **Pacific Dental School**

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing? 66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

The Health History is created and maintained by the University of the Pacific, Arthur A. Dugoni School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental.

Robert T. Lambing DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____