ALFRED B. DELA CRUZ, D.D.S.

FAMILY, COSMETIC, & IMPLANT DENTISTRY

REGISTRATION FORM

Welcome! Thank you for trusting us with your dental care. Our goal is to help you reach and maintain maximum oral health. In order for us to best serve you, we ask that you please complete *ALL 3 PAGES* of this registration form. All patient information is kept confidential. Thank You. (Please Print)

PATIENT INFORMATION

Patient's Name (Last, First, MI):	Gender: ☐ Female ☐ Male	Date of Birth:	Marital Status:

Patient or Guarantor's (if minor) Social Security Number (for billing purposes):	Driver's License Number:	State:

Home Phone:	Cell Phone:	E-mail Address (to confirm appointments):

Mailing Address (for billing purposes): (Street Address/ P.O. Box)	(City)	(State)	(Zip)
Residential Address (not P.O. Box): ☐ Same as mailing address above	(City)	(State)	(Zip)

Employment Information

Employer or School:	Work Phone:		
Employer or School Address: (Street Address)	(City)	(State)	(Zip)

Emergency Contact

Name:	Phone Number:	Relationship:

Whom may we thank for your referral?

☐ Personal Referral:	☐ PPO Insurance	☐ Diamond Certified
☐ Phonebook/Yellow Pages (Circle: SBC, Valley, United)	☐ Other	

PAYMENT INFORMATION & DENTAL INSURANCE

Method of payment for dental treatment/services (please select preferred method of payment):

[ ] Bill my dental insurance-complete information below

(However, I am responsible for any estimated deductible and/or co-pay at the time of service.)

[ ] Payment in full at each appointment (Cash, Check, Credit Card, CareCredit)

Who is responsible for this account (if patient is minor)?

PRIMARY INSURANCE (provide insurance card)			SECONDARY INSURANCE (if applicable)		
Name of Insured: (Last, First, Middle)		Date of Birth:	Name of Insured: (Last, First, Middle)		Date of Birth:
Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Dependent		Gender: ☐ M ☐ F	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Dependent		Gender: ☐ M ☐ F
Subscriber ID or SSN of Insured:			Subscriber ID or SSN of Insured:		
Insurance Company:	Group Number:		Insurance Company:	Group Number:	
Insurance Phone Number:	Employee ID Number:		Insurance Phone Number:	Employee ID Number:	
Insurance Mailing Address (Street Address/P.O. Box)			Insurance Mailing Address (Street Address/P.O. Box)		
City	State	Zip	City	State	Zip

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DENTAL HEALTH INFORMATION

What is the reason for your visit with us today?	Date of last visit to a dentist?	Date of last x-rays:

Name of previous dentist:	Phone number:	City/State:

Date of last visit to a dentist?	Date of last x-rays:	How may times do you floss in a week?	How many times do you brush in a day?

Has your doctor told you that you require antibiotics before receiving dental treatment?	Y	N
Are you currently in pain? If yes, please describe:	Y	N
Have you ever had a serious/difficult problem associated with any previous dental treatment? If yes, please describe:	Y	N
Do you or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)?	Y	N
Do you like your smile?	Y	N

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Bad Breath	Y	N	Grinding Teeth	Y	N	Sensitivity to Heat	Y	N
Bleeding Gums	Y	N	Jaw Clicking or Popping	Y	N	Sensitivity to Sweets	Y	N
Loose Teeth or Broken Fillings	Y	N	Red or White Patches	Y	N	Sensitivity When Biting	Y	N
Food Collection Between Teeth	Y	N	Sensitivity to Cold	Y	N	Sores or Growths in Your Mouth	Y	N

MEDICAL HEALTH INFORMATION

Name of primary care provider:	Phone number:	City:	May we contact your primary care provider if needed? ☐ Yes ☐ No

PLEASE ANSWER THE QUESTIONS BELOW. IF YOU ANSWER YES TO ANY OF THE QUESTIONS, PLEASE SPECIFY.

Currently under the care of a physician?	Y	N	Family history of cancer? If yes, specify.	Y	N
Smoke cigarettes and/or cigars? If yes, how much?	Y	N	Surgery/radiation therapy for tumor, cancer, or other condition of head or neck? If yes, specify.	Y	N
Do you drink alcohol? If yes, how much?	Y	N			
Serious trouble associated with any previous medical, dental, or surgical treatment? If yes, specify.	Y	N	Received or receiving bisphosphonate (Actonel, Boniva, Fosamax, Skelif, Didronel) therapy? When?	Y	N
Have you had any or do you currently have any serious medical illnesses? If yes, specify.	Y	N	Taken any of the group of drugs collectively referred to as "Fen-Phen"? Include combinations of Lonimin, Adipex, Fastin (brand name for phentermine), Pondimin (fenfluramine), or Redux (dexfenfluramine).	Y	N
Hospitalized within the past 5 years? If yes, specify.	Y	N			
Surgery/operation? If yes, specify.	Y	N			
Abnormal bleeding with previous surgery, extraction, or trauma? If yes, specify and how it was treated.	Y	N	Currently taking aspirin, warfarin, other blood thinners, or other anti-inflammatory drugs?	Y	N
Ever received a blood transfusion? If yes, specify.	Y	N	Women Only: Are you currently breastfeeding?	Y	N
Do you bruise easily?	Y	N	Women Only: Pregnant or possibly pregnant?	Y	N

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS LISTED BELOW?

AIDS/HIV positive	Y	N	Heart Murmur	Y	N	Mental or Nervous Disorder(s)	Y	N
Arthritis or Other Joint Problems	Y	N	Diabetes	Y	N	Fainting Spells/Seizures	Y	N
Artificial Joints or Heart Valves	Y	N	Kidney Disease	Y	N	Sinus Problem(s)	Y	N
Blood disorders (Anemia, Hemophilia, Sickle Cell Anemia)	Y	N	Hepatitis, Jaundice, Other Liver Disease	Y	N	Allergies, Hives, Rash, or Hay Fever	Y	N
Cancer If yes, please specify:	Y	N	Sexually Transmitted Disease(s)	Y	N	Asthma, Emphysema, Other Lung Disease	Y	N
Rheumatic Fever/Rheumatic Heart Disease	Y	N	Glaucoma Respiratory Problem(s)	Y	N	Persistent Cough/Coughing Up Blood	Y	N
Cardiovascular Disease (Heart Attack, Heart Surgery, Stroke, Angina, High Blood Pressure)				Y	N	Tuberculosis	Y	N
						Osteoporosis	Y	N

Other medical conditions not already specified:

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSELY TO (IF YES TO ANY, PLEASE SPECIFY REACTION):

Dental Anesthetics	Y	N	Tetracycline	Y	N	Erythromycin	Y	N	Aspirin	Y	N
Latex	Y	N	Penicillin	Y	N	Codeine or Other Narcotics	Y	N	Sulfa Drugs	Y	N

Other:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Patient:	Date:

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AUTHORIZATION AND RELEASE
NOTICE OF PRIVACY PRACTICE & DENTAL MATERIAL FACT SHEET

To better serve you, we ask that you please read all of the information below before signing below.

AUTHORIZATION AND RELEASE: I have completed the patient registration form and certify that this information is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and that it is my responsibility to inform the office of Dr. dela Cruz of any changes in my medical status. I authorize Dr. dela Cruz and the dental staff to perform the necessary dental services that I may need during diagnosis and treatment. I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurances have been made by anyone regarding the dental treatment which I have requested and authorized. I also authorize Dr. dela Cruz to release any information necessary to secure the payment of insurance benefits to Dr. dela Cruz. Regardless of my insurance status, I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered.

FOR NON-INSURED PATIENTS: Payment is expected in full with cash, check, Care Credit, or major credit card at the time of service.

FOR INSURED PATIENTS: Dental insurance policy is an agreement between the insured, the employer, and the insurance company. As a third party to this agreement, and out of courtesy for our patients, we will assist you in the preparation and submission of your dental claims. Please be aware that a majority of dental insurance plans do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and estimated patient portion on the day treatment is rendered. Although we strive to provide the best estimate(s) for dental services based on the information provided to us by your dental insurance company, please understand that these estimates are estimates only and are not a guarantee of payment by the dental insurance company. Please call your dental insurance company if you have any questions.

OVERDUE ACCOUNTS: Outstanding balances after 30-days are subject to a $2.00 billing charge and 1.5% monthly finance charge. In the event that your account becomes past due, it may be turned over to a collection agency and/or attorney. Should this occur, you agree to be responsible for all reasonable fees necessary for the collection of the account including, but not limited to, collection agency fees up to 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

CANCELLATIONS: I understand that appointments are scheduled exclusively for me and that a 48-hour notice is required if unable to keep a scheduled appointment. Otherwise, a fee will be assessed to my account for time reserved. (MINIMUM $50 PER HALF HOUR OF SCHEDULED APPOINTMENT).

RETURNED CHECKS: Checks returned for insufficient funds are subject to pursuant California Civil Code Section 1719.

I also acknowledge that I have received a copy of the following:
1) Notice of Privacy Practice. This document is not a contract, authorization, release or consent form.
2) Dental Materials Fact Sheet, "The Facts about Fillings," (May 2004) developed by the Dental Board of California.

My signature below acknowledges that I have read, understand, and have received the information above.

Signature (If minor, parent or guardian signature)	Date
X	

All of the above information is also available on our website www.YourSanRamonDentist.com
Thank You.

Patient:	Date: