PATIENT INFORMATION

DATE________________

NAME____ _MARRIED_SINGLE_MINOR_MALE_FEMALE

LAST FIRST MIDDLE

SOSIAL SECURITY # ____________________________

ADDRESS____

STREET APT# CITY STATE ZIP

BIRTHDATE______________ TELEPHONE____

MM/DD/YYYY HOME CELL WORK

E-MAIL________________________________

IF FULL TIME STUDENT, SCHOOL NAME____

Person Responsible For Account-Please Check One:_PATIENT_GUARDIAN_SPOUSE_PARENT

INSURANCE INFORMATION

PRIMARY INSURANCE

____

LAST FIRST MIDDLE

____

ADDRESS (IF SAME AS ABOVE WRITE : SAME)

____

BIRTHDATE MM/DD/YYYY

____

EMLOYER DENTAL INS. COMPANY

____

SS# SUBSCRIBER # GROUP #

SECONDARY INSURANCE

____

LAST FIRST MIDDLE

____

ADDRESS (IF SAME AS ABOVE WRITE : SAME)

____

BIRTHDATE MM/DD/YYYY

____

EMLOYER DENTAL INS. COMPANY

____

SS# SUBSCRIBER # GROUP #

EMERGENCY CONTACT INFO

Name____________________________

Address___________________________

____

Phone#___________________________

AUTHORIZATION

I hereby authorize payment directly to the Nataly Vilderman DDS. Inc. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Nataly Vilderman DDS. Inc. to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical histories are correct to best of my knowledge. I grant the right to Nataly Vilderman DDS. Inc. to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X_______________________________________

Patient or Responsible Party

Date __________ DL#_____________________

Whom may we thank for referring you to our office?

____

METHOD OF PAYMENT

_ Payment in full at each appointment(cash or check)

_ Payment in full at each appointment(Credit Card)

Card#_______________________Exp________

_ I wish to discuss the Office Financial Policy

Service Charge

If I do not pay the entire balance within 21 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or the future outstanding accounts.

PATIENT NAME____**DATE**_________________

Primary reason for this dental appointment: __Examination __Emergency __Consultation

DENTAL HISTORY

Do you have a specific dental problem?____Yes No

Do you have dental examinations on routine basis? Last visit_________________________________ Yes No

Do you think you have active decay or gum disease?_______________________________________Yes No

Do you brush and floss on routine basis? Discuss____ Yes No

Do your gums ever bleed? Discuss____ Yes No

Do you like your smile? Why?____ Yes No

Does food catch between your teeth? Any loose teeth?____________________________________Yes No

Do you want to keep your remaining teeth?____ Yes No

Do you ever have clicking, popping or discomfort in your jaw joint?____________________________ Yes No

Have your past experiences in a dental office always been positive?_____________________________Yes No

Do you smoke or chew tobacco? Any sore spots or growths in your mouth?_______________________Yes No

MEDICAL HYSTORY

Are you under a physician's care now? Why?____________Who?____________Phone____________Yes No

Have you ever been hospitalized or had a major operation? Discuss____________________________ Yes No

Have you ever had a serious injury to your head or neck? Discuss_____________________________ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?____________________ Yes No

Are you on a special diet? Discuss____ Yes No

Are You allergic to any medications or substances? Please check below __________________________Yes No

__ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex Rubber __ Milk __ Other_____________Yes No

Women (Please check)__Pregnant/trying to get pregnant __Nursing __Taking oral contraceptives________ Yes No

Do you have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate. If yes to any of the conditions, please call prior to your appointment...

	Y N		Y N		Y N		Y N		Y N
Heart disease/Surgery	__ __	Excessive Bleeding	__ __	Chemotherapy	__ __	Night Sweats	__ __	Cold Sores	__ __
Heart Murmur or Defect	__ __	Sickle Cell Disease	__ __	Osteoporosis	__ __	Yellow Jaundice	__ __	Fever Blisters	__ __
Irregular Heart Beat	__ __	Hemophilia	__ __	Bisphosphonates	__ __	Kidney Problems	__ __	Herpes	__ __
Angina/Chest pain	__ __	Methanoglobinemia	__ __	Osteonecrosis of jaw	__ __	Renal Dialysis	__ __	Stroke	__ __
Heart Attack/ Failure	__ __	Leukemia	__ __	Aredia I.V.Reclast I.V.	__ __	Thyroid Disease	__ __	Convulsions	__ __
Cong. Heart Disorder	__ __	Rsnt Blood Transfusion	__ __	Zometa I.V		Parathyroid Disease	__ __	Epilepsy/Seizures	__ __
Mitral Valve Prolapse	__ __	Swelling Limbs	__ __	Fosamax,Actonel,Boniva	_ _	Arthritis/Gout	__ __	Fainting Or Dizziness	_ _
Scarlet Fever	__ __	Lung Disease	__ __	Stomach/Intest. Disease	_ _	Rheumatism	__ __	Glaucoma	__ __
Rheumatic Fever	__ __	Breathing Problems	__ __	Ulcers	__ __	Pain in Jaw Joints	__ __	Tumors and Growths	_ __
Artificial Heart Valve	__ __	Shortness of Breath	__ __	Recent Weight Loss	__ __	Cortisone Medicine	__ __	Nervousness	__ __
Heart Pace Maker	__ __	Frequent Cough	__ __	Frequent Diarrhea	__ __	Artificial Joint	__ __	Psychiatric Care	__ __
Pulmonary Shunt	__ __	Hay Fever	__ __	Diabetes	__ __	STD	__ __	Alzheimer's Disease	__ __
High Blood Pressure	__ __	Sinus Trouble	__ __	Excessive Thirst	__ __	AIDS	__ __	Allergies(Medicines)	__ __
Low Blood Pressure	__ __	Asthma	__ __	Hypoglycemia	__ __	HIV Positive	__ __	Allergies(Pollen/Dust)	__
Bacterial Endocarditis	__ __	Bloody Sputum	__ __	Liver Disease	__ __	Genital Herpes	__ __	Hives or Rush	__ __
Unexpected Fever	__ __	Emphysema	__ __	Hepatitis A(Infectious)	_ _	Tatoos/Body Piersing	__ __	Need Premedication?	__ __
Bruise Easily/Blood Disease	_ _	Tuberculosis	__ __	Hepatitis B or C	__ __	Cochlear Implants?	__ __	Ever taken fen-phen?	__ __
Anemia	__ __	Cancer	__ __	Protease Inhibitor	__ __	Drug Addiction/Alcoholism	__ __		
Coronary Stent	__ __	X-Ray Treatment(Radiation)	__ __						

Have you ever had any other serious illness not checked above? Discuss __________________________ Yes No

Do you wish to talk to the dentist privately about any problem?________________________________ Yes No

To my best knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shell inform the dentist and the staff at the next appointment without fail.

X____ Date ____________________________

Nataly Vilderman, D.D.S
595 Buckingham Way, Suite 550
San Francisco, CA 94132
(415) 665-7800

Cancelation Policy

We appreciate our patients and their time. We know that last minute emergencies may arise. However, our office policy is that you notify us at least **48 hours** prior to your scheduled appointment if you will not be able to keep it. For your convenience, we do call to confirm your scheduled appointment 48 hours in advance. If your appointment is on a Monday you will be called the Thursday before due to the office being closed on Fridays. Please keep in mind that this is a courtesy call and if the appointment you reserved is not cancelled by our required 24 hour policy there will be a $50.00 charge applied. We thank you for your cooperation.

Sincerely,

Dr. Nataly Vilderman & Staff

I have read and understand the above mentioned matter.

____________________________________ ____________________

Patient Signature Date

Nataly Vilderman, D. D. S.
595 Buckingham Way, Suite 550
San Francisco, CA 94132
(415) 665-7800

Standard Dental Treatment Consent Form

We are complimented that you have selected us to provide dental care for you.

The undersigned herby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I understand that all responsibility for payment for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates I understand that a 1.5% (one and one half) percent finance charge (18% APR) will be added to my account and I agree to pay it.

____ ____________________
Print Name Date

____ ________________________________
Signature Signature of Responsible Party