



## BIRD ROCK DENTAL

**Philip A. Burgess, D.D.S. \* H. Kent Reed, D.D.S.**

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Dear New Patient,

We would like to take this opportunity to thank you for choosing us to serve your dental needs. We are committed in providing high quality and professional care utilizing proven techniques and equipment in a warm, friendly environment. We continually strive to meet the individual needs of our patients.

We pride ourselves in being a full service practice, not only in providing family dentistry, but many specialties such as gum therapy, root canals, cosmetic bonding and implant restorations. Nitrous oxide (laughing gas) is available for most procedures.

As a courtesy to our patients we will submit your insurance claims for you. Please assist us in serving you by completing the enclosed confidential patient information forms and bringing one signed and completed dental insurance form.

In order to accommodate your busy schedule, we do have early morning appointments available. The first and last appointments are prime schedule times, reserved for those with tight schedules.

For your convenience, there is street parking at our front entrance. Patient parking is also available behind our building, which is accessed from the alley. Physically impaired patients, please use the front entrance into our first floor reception room.

We do require and appreciate, at least 48 hours notice, if you are not able to keep your scheduled appointment. Please, whenever possible, let us know of your schedule change during our regular office hours. This will give another patient the opportunity to be seen.

Again, thank you and welcome.

Sincerely,

Drs. Burgess & Reed

For more information visit our website @ [www.birdrockdental.com](http://www.birdrockdental.com)



# Medical History

Patient's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Last                      First                      Initial                      Nickname

Patient's Guardian's Name \_\_\_\_\_

DENTAL HISTORY				MEDICAL HISTORY			
1	Is this your child's first visit?	YES	NO	1	Does your child have a health problem?	YES	NO
2	If not, how long since the last visit to the dentist?			2	Is your child under a physicians care? If yes, since when any why? _____	YES	NO
3	Were any x-rays taken at your child previous visit?	YES	NO				
4	Does your child eat between meals?	YES	NO	3	Name and phone number of physician?		
5	Does your child eat sweets, such as candy, soda pop, chewing gum?	YES	NO	4	Is your child receiving any medication? What?	YES	NO
6	When does you child brush his/her teeth? <input type="checkbox"/> Upon arising <input type="checkbox"/> After eating any food <input type="checkbox"/> Right after meals <input type="checkbox"/> Before going to bed						
7	Does your child receive Fluoride? <input type="checkbox"/> Community Water <input type="checkbox"/> Well Water <input type="checkbox"/> Fluoride drops <input type="checkbox"/> Fluoride rinse or gel	YES	NO	5	If your child allergic to penicillin, antibiotic or other drugs?	YES	NO
8	Have any cavities been noted in the past?	YES	NO	6	Is your child allergic to or sensitive to any metals or latex?	YES	NO
9	Were any teeth (baby or permanent) removed by extraction?	YES	NO	7	Has your child had any serious illness? When _____ What _____	YES	NO
	Was an appliance placed?	YES	NO				
10	Have there been any injuries to teeth, such as falls, blows, chips, etc.? If so describe? _____	YES	NO	8	Has your child ever had surgery?	YES	NO
				9	Does your child have a heart murmur?	YES	NO
11	Has your child had any problems with dental treatment in the past?	YES	NO	10	Does your child experience severe or prolonged bleeding?	YES	NO
12	Has any one in the family including parents had orthodontics?	YES	NO	11	Does your child have AIDS or has he/she tested HIV positive?	YES	NO
13	Has your child ever received a local anesthetic?	YES	NO	12	Has your child tested positive for hepatitis?	YES	NO
14	Has your child ever had occlusal sealants?	YES	NO	13	Is your child subject to nervous disorders? <input type="checkbox"/> Fainting? <input type="checkbox"/> Dizziness? <input type="checkbox"/> Seizures? <input type="checkbox"/> Behavioral/learning problems?		
15	Does your child think there is anything wrong with his/her teeth?	YES	NO			14	Does your child have frequent headaches?
				15	Has you child had history of: (circle the appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.		

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that the above information is complete and accurate.

Patient's/ Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Financial Policy

Thank you for choosing Bird Rock Dental as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

All patients must thoroughly complete our Patient Information form prior to seeing the doctor. We accept cash, personal checks, Visa, MasterCard and American Express.

### U.C.R (Usual & Customary Rates):

Our practice is committed to providing the best treatment possible for the lowest possible cost. However, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

### Payment for Services

All patients, regardless of age, are responsible for payment in full at the time of service.

### Regarding Insurance

Insurance is a contract **BETWEEN YOU AND YOUR INSURANCE COMPANY**. We are not a party to this contract. Reimbursement is subject to the terms of your contract with your carrier. However, we will assist in providing appropriate information to your insurance company for reimbursement.

Authorization to Release Information: I hereby authorize Bird Rock Dental, Drs. Burgess and Reed, to release any information to the insurance carrier acquired in the course of my examination or treatment.  
\_\_\_\_\_ (initials)

### Medi-Cal/ Denti-Cal/ Worker's Compensation

*IF THIS APPLIES TO YOU, PLEASE STOP HERE. WE ARE NOT CONTRACTED WITH ANY OF THE ABOVE AND THEREFORE ARE UNABLE TO OFFER ANY SERVICES.*

### Missed or Late Appointments

Unless cancelled at least two-(2) business days in advance, it is our policy to charge \$50 for missed appointments. The only exception is a situation that is out of your control, i.e. sickness, family or work emergencies. If you are over 20 minutes late arriving to your scheduled appointment there is a strong possibility that you will need to reschedule. Please help us serve you better by keeping your appointment with Bird Rock Dental.

Patient Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_