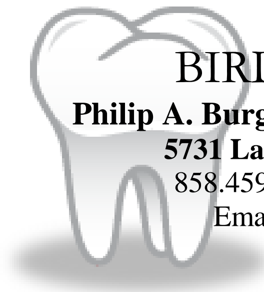

BIRD ROCK DENTAL

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

5731 La Jolla Blvd, La Jolla, CA 92037

858.459.0229 Web: birdrockdental.com

Email: info@birdrockdental.com

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

WELCOME

PATIENT INFORMATION

DATE ______________________

NAME: ____
Last First M

SOCIAL SECURITY#______________________

ADDRESS: ____
Street Apt#

DATE OF BIRTH ________________________
Month Day Year

____
City State Zip

O MARRIED O SINGLE O MINOR

TELEPHONE# ( ) __________________ ( ) ___________________ ( ) ___________________
Home Work Cell

O MALE O FEMALE

EMAIL ADDRESS ____

NAME OF EMPLOYER ____ADDRESS ____

EMERGENCY CONTACT ____

PERSON RESPONSIBLE FOR ACCOUNT (please check one):

- O PATIENT
- O GUARDIAN
- O SPOUSE
- O FATHER
- O MOTHER

Who may we thank for referring you to our office?

____

INSURANCE INFORMATION

Minor child-may need to complete both blocks for parent information
Adults – complete primary insured
Dual coverage- Also complete secondary insured

PRIMARY INSURED

Name_____________________________________Address____
Last First M Street City State Zip

Tel: ____Email: ____
Home Work Cell

____
Date of Birth Relationship to patient Employer Dental Ins. Co

____
Subscriber SS# Subscriber ID# Group #

SECONDARY INSURED

Name_____________________________________Address____
Last First M Street City State Zip

Tel: ____Email: ____
Home Work Cell

____
Date of Birth Relationship to patient Employer Dental Ins. Co

____
Subscriber SS# Subscriber ID# Group #

METHOD OF PAYMENT

Payment is required on the day and at the time of service.
Patient's portion not covered by insurance is due at time of service.
There is a $5.00 statement fee for those not paying at the time of service.
___ Payment in full at each appointment (cash or personal check)
___ Payment in full at each appointment __Visa __Master Card __American Express
Card # ________________________________ Exp. Date ______________
Also available is financing through Care Credit. www.carecredit.com

SERVICE CHARGE

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 affect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office 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 dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals by any method, including electric transfer.

X____ 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: __________

Dental History

WELCOME

Patient's Name____D.O.B_______________
Last First Initial

CIRCLE THE APPROPIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'TKNOW" AFTER THE QUESTION.

#	Question		
1	**Purpose of your visit**		
2	**Are you aware of any problems**		
3	**How long since your last dental visit?**		
4	**What was done at that time?**		
5	**Name of previous dentist** **Address:** **Tel.( )___________________________**		
6	**When was the last time your teeth were cleaned? _____________**		
7	**Did you make regular visits?** **How often?**	YES	NO
8	**Were dental x-rays taken?**	YES	NO
9	**Have you lost any teeth or have any teeth been removed?** **Why?**	YES	NO
10	**Have they been replaced?**	YES	NO
11	**How have they been replaced?** **a. Fixed bridge ___________________________Age____________** **b. Removable bridge ______________________Age____________** **c. Denture _________________________ _____Age____________** **d. Implant ______________________________Age____________**		
12	**Are you unhappy with the replacement?** **If yes, explain:**	YES	NO
13	**Would you like to know about permanent replacements?**	YES	NO
14	**Have you ever had any problems or complications with previous dental treatment?** **If yes, explain:**	YES	NO

#	Question		
15	**Do you clench or grind your teeth?**	YES	NO
16	**Does your jaw click or pop?**	YES	NO
17	**Have you experienced any pain or soreness in the muscles or your face or around your ear?**	YES	NO
18	**Do you have frequent headaches, neck aches, or shoulder aches?**	YES	NO
19	**Does food get caught in your teeth?**	YES	NO
20	**Are any of your teeth sensitive to:** **O Hot? O Sweets?** **O Cold? O Pressure?**		
21	**Do your gums bleed or hurt?** **When?**	YES	NO
22	**Do you experience dry mouth?**	YES	NO
23	**How often do you brush your teeth? ___________** **When?**		
24	**Do you use dental floss?**	YES	NO
25	**Are any of your teeth loose, tipped, shifted or chipped?**	YES	NO
26	**Are you unhappy with the appearance of your teeth?**	YES	NO
27	**Have you ever had gum treatment or surgery?** **What? ___________________________________** **Where? __________________________________** **When? __________________________________**	YES	NO
28	**Do you feel your breath is offensive at times?**	YES	NO
29	**Have you had any orthodontic work?**	YES	NO
30	**Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? (Please write it in the comments area)**	YES	NO
31	**How do you feel about your smile?**		
32	**Do you have any questions or concerns?** **If yes, explain:**	YES	NO

COMMENTS:____
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I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE____DATE_______________

DENTIST'S SIGNATURE____DATE_______________

Medical History

WELCOME

Patient's Name____D.O.B______________

Last First Initial

CIRCLE THE APPROPIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'TKNOW" AFTER THE QUESTION.

#	Question			#	Question		
1	Physician's Name______________________________ Address ____________________________________ ______________________Tel: ( )_____________			19	Do you have inflammatory disease, such as arthritis or rheumatism?	YES	NO
				20	Do you have any artificial joints/ prosthesis?	YES	NO
				21	Do you have any blood disorders, such as leukemia, etc?	YES	NO
2	Are you under physician's care? Since when _________________WHY___________	YES	NO	22	Have you ever bled excessively after being cut or injured?	YES	NO
				23	Do you have any stomach problems?	YES	NO
3	When was your last physical exam?			24	Do you have any kidney problems?	YES	NO
4	Are you taking any medications or substances? (If yes please list them below in the comments area)	YES	NO	25	Do you have any liver problems?	YES	NO
				26	Are you diabetic?	YES	NO
5	Do you routinely take health related substances? (vitamins, herbal supplement, natural products)	YES	NO	27	Do you have fainting or dizzy spells?	YES	NO
				28	Do you have asthma?	YES	NO
6	Are you allergic to any medications or antibiotics? (Ex. Penicillin, epinephrine)	YES	NO	29	Do you have epilepsy or seizure disorders?	YES	NO
				30	Do you or have you had venereal or any sexually transmitted disease?	YES	NO
7	Do you have any other allergies or hives?	YES	NO	31	Have you tested HIV positive?	YES	NO
8	Are you sensitive to metal or latex?	YES	NO	32	Do you have AIDS?	YES	NO
9	Are you pregnant or suspect you may be?	YES	NO	33	Have you had or do you test positive for hepatitis?	YES	NO
10	Do you use any birth control medication?	YES	NO	34	Do you or have you had TB?	YES	NO
11	Have you ever been treated or been told you might have heart disease?	YES	NO	35	Do you smoke, chew, use snuff or any other forms of tobacco?	YES	NO
12	Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?	YES	NO	36	Do you regularly consume more than one or two alcoholic beverages a day?	YES	NO
13	Have you ever had rheumatic fever?	YES	NO	37	Do you habitually use controlled substances?	YES	NO
14	Are you aware of any heart murmurs?	YES	NO	38	Have you had psychiatric treatment?	YES	NO
15	Do have HIGH or LOW blood pressure? (please circle one)			39	Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?	YES	NO
16	Have you ever had a serious illness or major surgery? If so, explain)________________________________	YES	NO	40	Do you have any disease condition, or problem not listed? If so, explain	YES	NO
				41	Is there anything else we should know about your health that we have not covered in this form?	YES	NO
17	Have you ever had radiation or chemo treatment for tumor growth or other conditions?	YES	NO	42	Would you like to speak to the Doctor privately about any problems?	YES	NO
18	Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis?	YES	NO				

COMMENTS:____
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I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE____DATE__________

DENTIST'S SIGNATURE____DATE__________