West Valley Periodontics

Patient First Name ________________________________ Middle Initial________ Last _______________________________________

Date of Birth ______________ Female / Male SS#____________________________Email_______________________________

Address____ City ________________State______ Zip____________

Home Phone Number _________________________ Cell Phone__________________________ Work Phone______________________

Employer______________________________Address______________________________________ Occupation____________________

If Minor, Name of parent or legal guardian____Relationship_______________________

Single / Married / Divorced / Other Spouse Name________________________ Emergency Phone ________________________

Whom may we thank for referring you? ______________________________ Dentist Name__________________________________

DENTAL BENEFITS INFORMATION

Primary Dental Benefit Company______________________________________ Phone Number________________________________

Address ____City________________State___________Zip___________________

Name of Policy Holder ____________________________________ Relationship to Patient__________________________________

Policy Holder's ID# or SSN# __________________________ Member's Date of Birth___________________ Group# _______________

Secondary Dental Benefit Company_____________________________________ Phone Number _______________________________

Address____City___________________State_________Zip__________________

Name of Policy Holder ____________________________________ Relationship to Patient__________________________________

Policy Holder's ID# or SSN# __________________________ Member's Date of Birth___________________ Group# _______________

CONSENT FOR SERVICES

I UNDERSTAND THAT PAYMENT FOR DENTAL SERVICES PROVIDED BY THIS OFFICE FOR EITHER ME OR MY DEPENDENT IS MY RESPONSIBILITY AND DUE AT THE TIME SERVICES ARE RENDERED.

I UNDERSTAND THAT ALL DENTAL SERVICES PROVIDED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE ENTIRE COST OF TREATMENT. AS A COURTESY, THIS OFFICE WILL ASSIST ME WITH PREPARING MY INSURANCE FORMS AND WILL MAKE EVERY EFFORT IN OBTAINING REIMBURSEMENT FROM MY INSURANCE COMPANY. I UNDERSTAND ANY DEDUCTIBLE AND ESTIMATED CO-PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE.

I give my consent to West Valley Periodontics to receive payment directly from my insurance company, but understand that this office cannot render services based on the assumption that insurance company will pay. I agree to notify the office immediately if there are any changes regarding my dental benefits.

I hereby authorize West Valley Periodontics to release any of information that may be required by my dental benefits company, third party and/or healthcare provider.

I have read and understand the above conditions regarding my dental benefits.

____ ____________________

Signature of Patient, parent or legal representative Date

West Valley Periodontics

Patient's Name____ DOB______________________ Date______________________

Reason for your visit today____ Are you in dental discomfort: YES/NO

Check if you have problems with any of the following:

_____Bad Breath _____Bleeding Gums _____Periodontal treatment _____Temperature sensitivity: Hot / Cold
_____Sensitivity to sweets _____Clenching or grinding _____Sensitivity when biting
_____Snoring _____Mouth breathing _____Dry mouth

Any adverse reaction during or in conjunction with a medical or dental Procedure _______________________________________
Any serious illness or operations: ____ Date__________________________________
Blood Transfusion_______________________________ Artificial Joints ________________________Date____________________
Cancer____ Heart Attack __________________________Date____________________
Heart Surgery_________________________ Date______________ Stroke______________________ Date________________
Pacemaker______________________________ Neurologic/Emotional Condition____
History of bisphosphonates?_________ Reason __________________ Date ____________ IV _____ Oral_____(please list med below)
Diabetes? ____________ A1C_____________ Date of last checked______________
PREFERRED PHARMACY AND CROSS STREETS: ____

Please check medical conditions that apply to you:

☐AIDS/HIV	☐Cancer	☐Headache/ Migraines	☐Kidney Disease	☐Sinus Problems
☐Anemia	☐Chemotherapy	☐Head Injuries	☐Liver Disease	☐Smoke/ Chew Tobacco
☐Angina	☐Circulatory Problems	☐Heart Attack	☐Mental Disorders	☐Stomach Problems
☐Arthritis	☐Cold Sores	☐Heart Disease	☐Nervous Disorders	☐Stroke
☐Artificial Joints	☐Diabetes	☐Heart Murmur	☐Pregnancy	☐Thyroid Disorder
☐Asthma	☐Dizziness/ Vertigo	☐Hepatitis	☐Premed	☐Tuberculosis
☐Back Problems	☐Epilepsy	☐Herpes	☐Radiation Treatment	☐Tumors
☐Blood Disease	☐Excessive Bleeding	☐High Blood Pressure	☐Respiratory Problems	☐Ulcers
☐Blood Thinners	☐Fainting	☐Jaundice	☐Rheumatic Fever	☐Venereal disease
☐Blood Transfusion	☐Glaucoma	☐Jaw Pain	☐Rheumatism	☐Cholesterol

Other____

ALLERGIES

☐Codeine ☐Latex ☐Morphine ☐Penicillin ☐Amoxicillin ☐Sulfa Drugs ☐Local Anesthetic
☐Aspirin ☐Narcotics

Other ____

MEDICATIONS/VITAMINS/SUPPLEMENTS (IF NO CHANGES, PLEASE LIST "NO CHANGES")

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West Valley Periodontics

PATIENT NAME ____ DATE OF BIRTH____________________________

I VERIFY THAT THE INFORMATION GIVEN ON HEALTH HISTORY FORM IS TRUE AND CORRECT.

- I understand that the office and staff of West Valley Periodontics will make every reasonable effort to protect my personal health information, including my social security number, date of birth, address and phone numbers.
- I understand that there may be times when the doctor and staff will need to speak with me regarding an appointment time, a test result, or financial arrangements. If I am not available, they have my permission to leave a brief message at my home or work number provided.
- I give my permission to West Valley Periodontics and staff to correspond with my general dentist, general physician, or specialist that I am under care with.
- Upon my request, I will be given a full and complete copy of HIPAA privacy policy.

In addition to my dentist, physician and dental benefit company, I authorize West Valley Periodontics to discuss my personal information with the following people:

____ ____
NAME RELATION

____ ____
NAME RELATION

____ ____
NAME RELATION

____ ___________________
SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE DATE

West Valley Periodontics

OFFICE FINANCIAL POLICY

Our goal at **West Valley Periodontics** is to ensure that you have an outstanding experience in our office. We are committed to supporting you in understanding your dental health, so that you will always be able to make the best choices in regards to your treatment. We are here to assist you in any way possible. Please make your questions and concerns known to our team.

In our continued commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you the following payment options.

- **Debit – Visa or Mastercard**
- **Visa or MasterCard Credit Cards – there would be a 3% fee applied to payments over $300.**
- **Check (There will be a $35.00 charge for any returned check)**
- **Cash**

We also offer financial options by Care Credit
Please ask our administrative staff for details and credit applications

1. I understand that payment for dental services provided by Dr. Aziz Bohra , Dr. Martin, Dr. Trevor Siu or Dr. Clark Chen, for either me or my dependent is my responsibility and due and payable at the time services are rendered.
2. **Patients with dental insurance**: As a courtesy, West Valley Periodontics will submit my insurance forms and will make every effort in obtaining reimbursement from my insurance company. I understand that all dental services provided are charged directly to me and that I am personally responsible for entire cost of treatment. I understand any deductible and estimated co-payments are **due in full at the time of service** and it is my responsibility to follow up with my insurance.
3. I give my consent to allow **West Valley Periodontics** to receive payment directly from my dental benefits company, but understand that this office cannot render services based on the assumption that a dental benefit company will pay. I agree to notify the office immediately if there are any changes regarding my benefit coverage.
4. As a condition of my treatment by West Valley Periodontics, any financial arrangement must be made in ADVANCE, prior to the actual treatment; I understand the practice depends upon financial reimbursement from its patients.
5. A finance charge of 3% per month on the unpaid balance will be charged on all accounts exceeding 30 days, unless a previously written and signed financial agreement exists and is being satisfied. I further agree to pay all financial charges, collections cost, attorney fees, and any other costs that may incurred to enforce collection of any amount outstanding on my account.
6. **In an effort to offset rising credit card costs, a 3.00% fee will be applied to sales settled by Credit Cards over $300 and does not apply to Debit cards.**
7. I agree to pay the fee of $35.00 for any returned checks.
8. ***A fee of $100 PER HOUR, per schedule treatment*** *will be charged for MISSED OR CANCELLED appointments WITHOUT* ***48 HOUR NOTICE.***
9. All emergency services, or any other dental services performed without previous financial arrangements, must be paid for in full at the time of services.
10. I authorize **West Valley Periodontics** to release any of my information that may be required to my dental benefits company, third party payer and/or healthcare practitioner.
11. I grant my permission to **West Valley Periodontics** or your assignee to telephone me at home or at my work to discuss matters related to this form.
12. I have read the above conditions of treatment and agree to their content.

______________________________________ __________________________
PRINTED NAME OF PATIENT DATE

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SIGNATURE OR PATIENT, PARENT OR LEGAL REPRESENTATIVE