Pleasant Hill Dentistry
Randy B. Bautista D.D.S. , Inc.

140 Gregory Lane Suite #200
Pleasant Hill, CA 94523
925-685-8587 Ph/925-685-7009 Fax

Patient Information (Confidential)

Name_______________________________________ Date____________
First Middle Last

Address____________________ City____________________State__________Zip_______
Cell #__________________ Soc. security #______________Birth date______________Home phone____________
Email ____

Check Appropriate Box ☐ Minor ☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

If college student, F.T./P.T., name of school__________________________City______________State_______
Patient's or parent's employer____________________________________ Work phone________________
Business address ____________________ City____________________State______________Zip_______

Spouse or parent's name Employer____________________Work phone____________________

Person to contact in case of an emergency Phone________________________

How did you hear about our office ____

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient______________
Address ____Home Phone________________
Driver's license #______________________Birth date______________Soc. security #________________
Employer ____ Work phone________________
Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured ______________________________________ Relationship to patient______________
Birth date______________________ Soc. security #__________________Date employed______________
Name of employer________________ Union or local #__________________Work phone______________
Insurance co.______________________ Tel. #________________Grp. #__________Policy/I.D. #__________
Ins. co. address____________________ City____________________State____________Zip__________

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________________________________ Relationship to patient______________
Birth date______________________ Soc. security #__________________Date employed______________
Name of employer________________ Union or local #__________________Work phone______________
Insurance co.______________________ Tel. #________________Grp. #__________Policy/I.D. #__________
Ins. co. address____________________ City____________________State____________Zip__________

X____________________________________ ________________________

Signature of patient (or parent if minor) **Date**

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Financial Policy

The dental office of Dr. Randy Bautista DDS Inc. is committed to providing the best possible care. In order to provide the best treatment available we have several financial policies. If you have dental insurance we will help you receive the maximum allowable benefits. In order to do this we need your assistance and your understanding to our policy.

Payment is due at the time service provided, unless other payment arrangements are made in advance. We accept **Cash, Check, Visa, Master Card** and **Care Credit**. We will be happy to process your insurance claim as a courtesy to you. If you have insurance please be prepared to pay your portion of treatment rendered. If you have no insurance coverage payment is expected in full unless other financial arrangements are made.

If less than a **24 hour** notice is given a **$50** charge will be implemented for a failed or a late cancelled appointment. All balances that are past due for over 30 days will be charged a finance fee of 1%. We would be glad to discuss your proposed treatment and answer any question relating to your insurance coverage.

You must realize however that:

1. Your insurance is a contract between you, your employer, and the insurance company.
2. Dental insurance is not meant to pay all, it is only meant to be an aid. Many routine dental visits are not covered by your dental plan. If you have any questions regarding your coverage you should contact your insurance carrier. It is your responsibility to know your coverage.

We must emphasize that as a dental care provider our relationship is with you not your insurance company. While the claim processing is a courtesy we extend to our patients, all charges are your responsibility.

If you have any questions about the above information or are uncertain regarding insurance information, please do not hesitate to ask our front desk. We are here to help you.

X____ ________________________

Signature of patient (or parent if minor) **Date**

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Patient Medical History

Patient's Name______________________________ **Date of Birth**______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health? ____	☐	☐
2. Have there been any changes in your general health within the past year ____	☐	☐
3. Date of your last physical exam ____		
4. Physician's Name / Location ____		
Phone no.____		
5. Are you now under the care of a physician ____	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness____	☐	☐
Please explain ____		
7. Are you taking any medicine(s), including non-prescription medicine? ____	☐	☐
If yes, what medicine(s) are you taking ____		

Are you allergic to or have you had reactions to:	YES	NO
Local anesthetics like novocaine ____	☐	☐
Penicillin or other antibiotics____	☐	☐
Any metals (e.g., nickel, mercury, etc.) ____	☐	☐
Latex/rubber____	☐	☐
Other (please list)____		

Women only:

	YES	NO
Are you pregnant /may be pregnant____	☐	☐
Are you nursing ____	☐	☐
Are you taking birth control pills ____	☐	☐

YES NO

Do you have, or have you ever had, any of the following:

	YES	NO
High/low blood pressure____	☐	☐
Abnormal bleeding ____	☐	☐
Blood transfusion ____	☐	☐
Fen-Phen or Redux ____	☐	☐
Tobacco ____	☐	☐
Controlled substances ____	☐	☐
Rheumatic heart disease/ rheumatic fever ____	☐	☐
Chest pain ____	☐	☐
Heart defect or heart murmur____	☐	☐
Heart trouble, heart problems, or surgeries ____	☐	☐
Mitral valve prolapse ____	☐	☐
Stroke____	☐	☐
Pacemaker____	☐	☐
Shortness of breath ____	☐	☐
Hepatitis, jaundice, or liver disease ____	☐	☐
Sinus trouble ____	☐	☐
Lung or breathing problems ____	☐	☐
Asthma or hay fever ____	☐	☐

	YES	NO
Fainting or dizzy spells____	☐	☐
Diabetes____	☐	☐
AIDS or HIV infection ____	☐	☐
Thyroid problem ____	☐	☐
Joint replacement or implant ____	☐	☐
Stomach ulcer ____	☐	☐
Kidney trouble ____	☐	☐
Tuberculosis____	☐	☐
Chemotherapy (cancer, leukemia)____	☐	☐
Sexually transmitted disease ____	☐	☐
Epilepsy or seizures____	☐	☐
Anemia____	☐	☐
Nervousness ____	☐	☐
Tumors____	☐	☐
Mental health care ____	☐	☐
Back problems ____	☐	☐
Chemical dependency ____	☐	☐

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Cold sores/fever blisters___________________ ☐ ☐

Do you have any disease, condition, or problem not listed that you think I should know about ___☐ ☐

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Patient Dental History

Patient's Name ______________________________ **Date of Birth**____________

Reason for this visit______________________________
When was your last dental visit______________________What was done then______________
Previous dentist (name and location) ______________________________
Have you had a complete series of dental exams (x-rays) taken? When and where ______________________
How often do you brush your teeth ____________________ How often do you floss your teeth______________

	YES	NO
Do you feel pain on any of your teeth ________	☐	☐
Have you noticed any loosening of your teeth ________	☐	☐
Do your gums bleed while brushing or flossing________	☐	☐
Are your teeth sensitive to hot or cold liquids/foods ________	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods ________	☐	☐
Do you have any sores or lumps in or near your mouth ________	☐	☐
Do you have frequent headaches ________	☐	☐
Do you bite your lips or cheeks frequently ________	☐	☐
Does food tend to become caught between your teeth________	☐	☐
Have you ever had periodontal treatment (gums)________	☐	☐
Ever worn a bite plate or other appliance ________	☐	☐
Have you ever had any difficult extractions in the past________	☐	☐
Have you ever had any prolonged bleeding following extractions ________	☐	☐

	YES	NO
Do you wear dentures or partials ________	☐	☐
If yes, date of placement ________		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums________	☐	☐
Have you had ortho/braces in the past ________	☐	☐
Have you had any head, neck, or jaw injuries________	☐	☐
Do you clench or grind your teeth ________	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking ________	☐	☐
Pain (joint, ear, side of face) ________	☐	☐
Difficulty in opening or closing________	☐	☐
Difficulty in chewing________	☐	☐
Have you had an unfavorable dental experience ________	☐	☐

Would you be interested in teeth whitening ________	☐	☐
Would you be interested in straighter teeth________	☐	☐
Would you be interested in veneers / crowns replaced________	☐	☐
Would you be interested removing mercury/silver fillings ________	☐	☐

If you could change anything about your smile, what would you change? ______________________________
____
____

Appointments: A minimum charge will be made for **failed** or **cancelled** appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________________Date____________

Signature of patient or parent if minor

Doctor's Comments____
____
____________________**Signature**____________________**Date**____________

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