Evergreen Valley Dental Office
4868 San Felipe Rd, Suite 120, San Jose, CA 95135 · (408) 528-8303

New Patient Registration

PATIENT INFORMATION

Patient Name (Last, First, MI) _____ Preferred Name _____ Date _____

Date of Birth _____ Gender _____ Family Status _____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____

Preferred appointment time: [ ] Morning [ ] Afternoon [ ] Evening [ ] Any Time

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

HEALTH INFORMATION

Date of Last Dental Visit _____ Reason for This Visit _____

Please check any of the following that apply to you:

[ ] AIDS	[ ] Anemia	[ ] Arthritis	[ ] Artificial Joints / Valves
[ ] Asthma	[ ] Blood Disease	[ ] Cancer	[ ] Diabetes
[ ] Dizziness / Fainting	[ ] Epilepsy	[ ] Excessive Bleeding	[ ] Glaucoma
[ ] Growths / Tumors	[ ] Hay Fever	[ ] Head Injuries	[ ] Heart Disease
[ ] Heart Murmur	[ ] Hepatitis	[ ] High Blood Pressure	[ ] Jaundice
[ ] Kidney Disease	[ ] Liver Disease	[ ] Nervous Disorders	[ ] Pacemaker
[ ] Radiation Treatment	[ ] Respiratory Problems	[ ] Rheumatic Fever	[ ] Rheumatism
[ ] Sinus Problems	[ ] Stomach Problems	[ ] Stroke	[ ] Tuberculosis
[ ] Venereal Disease	[ ] Codeine Allergy	[ ] Penicillin Allergy	[ ] Latex Allergy
[ ] Mental Health Conditions	[ ] Pregnancy (if applicable)		

If you checked any item above, please briefly explain:

_____

Have you had complications following dental treatment? [ ] Yes [ ] No — if yes, please explain:

_____

Have you been hospitalized or needed emergency care in the past two years? [ ] Yes [ ] No

Are you currently under the care of a physician? [ ] Yes [ ] No — Physician name / phone:

_____

Are you currently taking any medications? [ ] Yes [ ] No — if yes, please list:

_____

I confirm that the information above is true and accurate to the best of my knowledge. I will inform the doctors of any change in my health at my next appointment.

Signature of Patient / Parent / Guardian _____ Date _____

REFERRAL INFORMATION

How did you hear about our practice?
[ ] Another Patient [ ] Insurance Listing [ ] Online Search [ ] Social Media [ ] Flyer / Mailer [ ] Other

Name of person or office referring you (if applicable) _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

This information is for: [ ] Patient's Spouse [ ] Person Responsible for Payment

Name _____ Relationship _____

Date of Birth _____ Phone _____ Best Time to Call _____

Address _____ City / State / Zip _____

EMPLOYMENT INFORMATION

Employer Name _____ Occupation _____

Employer Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance

Name of Insured _____ Relationship to Insured _____

Insurance Plan Name _____ Group # _____ ID # _____

Secondary Insurance (if applicable)

Name of Insured _____ Relationship to Insured _____

Insurance Plan Name _____ Group # _____ ID # _____

CONSENT FOR SERVICES

Payment for treatment is arranged in advance and is due at the time services are provided, unless other financial arrangements have been made with our office. If treatment is performed without prior financial arrangements, payment is due in full at the time of service.

I understand that I am personally responsible for payment for all dental services provided, regardless of any dental insurance I may carry. As a courtesy, our office will help prepare and submit insurance claims on my behalf, but any amount not covered by insurance remains my responsibility. A finance charge may apply to balances unpaid after 60 days.

I authorize the release of any information required to process insurance claims, and I authorize insurance payments to be made directly to this office. I have read and understand the above terms.

Signature of Patient / Guarantor _____ Date _____

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General Dentistry Informed Consent

Patient Name _____ Date _____

1. X-Rays & Initial Oral Examination

To properly diagnose any treatment or evaluate an area of concern, we may need to take X-rays and perform a routine oral examination.

Initials: _____

2. Medications & Sedation

Medications used in dental care, including antibiotics, can occasionally cause an allergic reaction or other side effects. Taking antibiotics may also reduce the effectiveness of certain other medications, including birth control. Patients should not drive or operate machinery for at least 12 hours, or until fully recovered, after receiving sedation or anesthesia in our office.

Initials: _____

3. Changes in Treatment Plan

During treatment, it may become necessary to adjust or add procedures based on conditions found that were not apparent during the initial exam (for example, a root canal becoming necessary during a routine restorative procedure). I give the dentist permission to make reasonable changes and additions as needed.

Initials: _____

4. Amalgam (Silver) Fillings

If amalgam filling material is recommended, I understand it contains mercury and that potential health considerations and alternative options have been explained to me.

Initials: _____

5. Composite (White) Fillings

I understand the benefits of composite (tooth-colored) fillings, that the cost is typically higher than amalgam, and that my insurance plan may not cover all or part of the cost.

Initials: _____

I authorize and understand that each dentist is an individual practitioner, individually responsible for the dental care rendered to me. I understand that no other dentist besides my treating dentist is responsible for my dental treatment, and I acknowledge receipt and understanding of all post-operative instructions provided to me.

Patient Signature _____ Date _____

Doctor / Witness Signature _____ Date _____

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Financial Responsibility Agreement

Patient Name _____ Date _____

I acknowledge full financial responsibility for services rendered to me by Evergreen Valley Dental Office. I understand that payment for charges incurred is due at the time service is provided, unless other specific financial arrangements have been made in advance.

I further authorize Evergreen Valley Dental Office to receive insurance payments directly on my behalf, should my insurance carrier elect to pay the practice directly. Any balance not covered by insurance, including any balance resulting from a lapse in coverage, remains my responsibility.

I confirm that I have read and fully understand the financial responsibility and insurance authorization described above.

Signature _____ Date _____

Name (Printed) _____