FREMONT DENTAL EXCELLENCE
1895 Mowry Ave Suite#120
Fremont, California 94538
(510)494-8181
www.fremontdentalx.com

1 PATIENT INFORMATION

Date_____
SS#_____
Patient Name_____
Address_____
City_____ State_____ Zip Code_____
Sex M__ F__ Age_____
Birth date_____ Minor __
Married __ Widowed __ Single __
Separated __ Divorced __ Partnered for __ years
E-mail_____
By providing your email, you consent to being contacted by us regarding treatment or account information.

Patient Employer/School_____
Occupation_____
Employer/School Address_____
_____
Employer/School Phone (___) _____
Spouse's Name_____
Birth date_____
SS#_____
Spouse's Employer_____
Occupation _____
Whom may we thank for referring you? _____
If you were not referred to us, how did you hear about our practice? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to patient_____
Insurance Co._____
Group #_____
Is the patient covered by additional insurance? N___ Y___
Subscriber's Name_____
Birthdate_____ SS#_____
Relationship to patient_____
Insurance Co._____
Group #_____

ASSIGNAMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Co.)
And assign directly to Dr. Gustavo Lemus all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date **Relationship to Patient**

3 PHONE NUMBERS

Home (___) _____ Work (___) _____ Ext_____ Cell Phone (___) _____
By providing your cell phone number, you consent to being contacted at that number by our practice and our agents regarding treatment and/or account.
Best time and phone number to reach you _____ Do you prefer text appointment reminders? Y___ N___
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household).
Name_____ Relationship_____
Phone (___) _____

4 DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____
Date of last dental visit_____
Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath yes__ no___
Bleeding gums yes__ no___
Blisters on lips or mouth yes__ no___
Burning sensation on tongue yes__ no___
Chew on one side of mouth yes__ no___
Cigarette, pipe, or cigar smoking yes__ no___
Clicking or popping jaw yes__ no___
Dry mouth yes__ no___
Fingernail biting yes__ no___
Food collection between the teeth yes__ no___
Foreign objects yes__ no___
Grinding teeth yes__ no___
Gums swollen or tender yes__ no___
Jaw pain or tiredness yes__ no___
Lip or cheek biting yes__ no___
Loose teeth or broken fillings yes__ no___
Mouth breathing yes__ no___
Mouth pain, brushing yes__ no___
Orthodontic Treatment yes__ no___
Pain around ear yes__ no___
Periodontal Treatment yes__ no___
Sensitivity to cold yes__ no___
Sensitivity to heat yes__ no___
Sensitivity to sweets yes__ no___
Sensitivity when biting yes__ no___
Sores or growths in your mouth yes___ no___

How often do you floss? _____

How often do you brush? _____

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5 HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "**fen-phen**"? These include combinations of **Ionimin, Adipex, Fastin** (brand names of **phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)**. Yes____ No_____

Bisphosphonate Medication (Fosomax, Actonel, Boniva, Aredia, Bonefos, Didronel, Zometa). Yes____ No_____

Please mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	yes___ no___	Epilepsy	yes___ no___	Respiratory Disease	yes___ no___
Anemia	yes___ no___	Fainting or dizziness	yes___ no___	Rheumatic Fever	yes___ no___
Arthritis, Rheumatism	yes___ no___	Glaucoma	yes___ no___	Scarlet Fever	yes___ no___
Artificial Heart Valves	yes___ no___	Headaches	yes___ no___	Shortness of breath	yes___ no___
Artificial Joints	yes___ no___	Heart Murmur	yes___ no___	Sinus Trouble	yes___ no___
Asthma	yes___ no___	Heart problems	yes___ no___	Skin rash	yes___ no___
Back problems	yes___ no___	Hepatitis Type_____	yes___ no___	Special Diet	yes___ no___
Bleeding abnormally, with extractions or surgery	yes___ no___	Herpes	yes___ no___	Stroke	yes___ no___
		High Blood Pressure	yes___ no___	Swollen feet or ankles	yes___ no___
Blood Disease	yes___ no___	Jaundice	yes___ no___	Swollen neck or gland	yes___ no___
Cancer	yes___ no___	Jaw Pain	yes___ no___	Thyroid problems	yes___ no___
Chemical dependency	yes___ no___	Kidney Disease	yes___ no___	Tonsillitis	yes___ no___
Chemotherapy	yes___ no___	Liver Disease	yes___ no___	Tuberculosis	yes___ no___
Circulatory problem	yes___ no___	Low Blood Pressure	yes___ no___	Tumor or growth on the head or neck	yes___ no___
Congenital Heart Lesions	yes___ no___	Mitral Valve Prolapse	yes___ no___		
Cortisone Treatments	yes___ no___	Nervous problems	yes___ no___	Ulcer	yes___ no___
Cough, persistent or bloody	yes___ no___	Pacemaker	yes___ no___	Venereal Disease	yes___ no___
Diabetes	yes___ no___	Psychiatric treatment	yes___ no___	Weight Loss unexplained	yes___ no___
Emphysema	yes___ no___	Radiation treatment	yes___ no___		

Do you wear contact lenses? yes___ no___

Women:

Are you pregnant? yes___ no___ Due date_____ Are you nursing? yes___ no___ Taking birth control pills? yes___ no___

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name_____

Phone (____) _____

ALLERGIES

Aspirin yes____ no___ Local Anesthetic yes____ no_____

Barbiturates (sleeping pills) yes___ no___ Penicillin yes____ no_____

Codeine yes___ no____ Sulfa yes_____ no____

Iodine yes____ no____ Other_____

Latex yes____ no____ _____

Patient's Signature_____ Date _____

Doctor's Signature_____ Date_____

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CANCELLATION/BROKEN APPOINTMENT POLICY

We will make every effort to accommodate your scheduling needs. In return we ask that you help us out by keeping your appointments, and by notifying us in advance if you are unable to do so. With advance notice, we are often able to accommodate other patients that are willing to get an appointment.

IF YOU NEED TO CANCEL AN APPOINTMENT, PLEASE NOTIFY US 48 HOURS IN ADVANCE.

ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 48 HOURS ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE OF $50.00 PER HOUR SCHEDULED.

We thank you for your assistance in complying with this policy and appreciate your cooperation.

_____ _____

Patient's/patient's guardian signature Date

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Written Financial Policy

Thank you for choosing Fremont Dental Excellence. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa, Mastercard, American Express or Discover Card
- Convenient Monthly Payment Plans[1] from a third party financing company

  Allows you to pay over time

Please note:

Fremont Dental Excellence requires payment when services are rendered.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]**However, if we do not receive payment from your insurance carrier, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.**