We are pleased to welcome you to our practice. Please take a few minutes to fill out this form.
If you have any questions, we'll be glad to help you.

Jorge E. Vallejo, DMD

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Email _____

Patient _____
Last Name First Name Middle Initial Preferred

Street Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Sex: ☐ M ☐ F Age _____ Birthdate ____/____/____ (mm dd yy)

☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Patient's Social Security #/TIN _____ Spouse/Parent's S/S #/TIN _____

Spouse/Parent Name _____ Spouse/Parent Birthdate ____/____/____

Dental Insurance - Name & Phone # _____ Group# _____

In case of emergency, who should be notified? _____ Phone (____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical ____/____/____

Have you ever had any of the following? (please check boxes below):

AIDS	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Alcohol Dependency	☐ Yes ☐ No	Drug Dependency	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Sickle Cell	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Taking Aspirin	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Taking Diet Medications	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Blood Disorder	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Hepatitis (Type A,B,C)	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	**Are you allergic to:**	
Chemical Dependency	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Latex	☐ Yes ☐ No
Cholesterol	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Congenital Heart Valve	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Other	
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	_____	
Cough (Persistent/Bloody)	☐ Yes ☐ No				

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medications at this time? ☐ Yes ☐ No If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No For what condition(s)? _____

Do you suspect that you are pregnant? ☐ Yes ☐ No Take birth control pills? ☐ Yes ☐ No

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I/my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of ______________________________
And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including and not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE POLICY/ASSIGNMENT AND RELEASE

Your insurance is a contract between you, your employer and insurance company. We are not a party to that contract. We do not participate with **ANY** plan. We are willing to help you receive your maximum allowable benefits by processing your insurance claims for you. In order to achieve these goals, we need your assistance. It is your responsibility to verify benefit coverage for any services performed in this facility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. Your signature below will authorize us to use it on all insurance submissions and allows assignment of benefits if we are to receive the insurance payment. **Our payment policy is as follows:**

1. Patient's whose insurance carriers send payment directly to patient will have to pay for their treatment at time of service
2. Patient's whose insurance carriers send payment to our office will have to pay the co-pay and deductible (if applicable) for their treatment at time of service.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges for services or items provided to me or the patient. Payments can be made by cash, check or credit card. We also participate with Care Credit, which is similar to a credit card and used for dental treatment only. A $30 fee will be imposed on any checks returned for insufficient funds

APPOINTMENTS

If you cancel an appointment with less than 24 hours notice or fail to appear for your scheduled time, there will be a $60 broken appointment charge.

____ ______________________
Signature of Patient/Parent, Guardian or Personal Representative Date

____ ______________________
Please print name of Patient/Parent, Guardian or Personal Representative Relationship to Patient

Office Use:

MEDICAL HISTORY UPDATE

Date____________ Has there been any change in the patient's health since the last dental appointment? □ Yes □ No
For what conditions?______________________________
Is the patient taking any new medications? □ Yes □ No If so, what?______________________
Patient/Guardian's Initials____________

MEDICAL HISTORY UPDATE

Date____________ Has there been any change in the patient's health since the last dental appointment? □ Yes □ No
For what conditions?______________________________
Is the patient taking any new medications? □ Yes □ No If so, what?______________________
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Patient/Guardian's Initials____________