Hillcrest Periodontics
Stephen H. Munroe, D.D.S., A Dental Corporation
1000 West Washington St. Suite One
San Diego, California 92103
Office: (619) 297-0700
Fax: (619) 704-0688

Patient Information & Medical History

The following is confidential information and is for our records only. If you have any questions, please contact one of our staff members. We will be happy to help you.

Name (Last):_____(First):_____(Preferred):_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: ____Male ____Female Birthdate:_____ S.S.#(for insurance purposes only):_____

E-Mail Address (Used only for contacting you regarding your appointments):_____

Which days and times are the best for you to be scheduled? Days:_____ Time:_____

How would you like us to confirm your appointments? (Circle one) Home Cell Work E-mail

Employer_____Occupation:_____

Responsible Party/Guardian/Parent Name:_____Birthdate:_____

Emergency Contact:_____Phone:_____

REFERRED BY_____

GENERAL DENTIST: _____

If not referred, how did you find us? Yelp! Friend Web Search Other_____

Dental Insurance Claims Information

Dental insurance is a benefit purchased by or for the patient. We cannot be responsible for what you have purchased. As a courtesy we will fill out and file a claim for you, but you are responsible for the entire bill. If the information you supply is incomplete or inaccurate, you will be responsible for full payment to our office and filing with your insurance carrier will be your responsibility.

Insured Name:_____ Relationship: SELF SPOUSE PARENT OTHER

Insurance Company Name:_____SS or ID# of Insured:_____

Employer Name:_____Birthdate of Insured:_____

Release and Assignment

I hereby authorize release of any information, including the diagnosis and records of any treatments or examination rendered, to my insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursement, directly to the doctor, of benefits to which I am entitled.

SIGNATURE:_____DATE:_____

Medical History

ARE YOU <u>ALLERGIC</u> TO OR HAD A REACTION TO ANY OF THE FOLLOWING MEDICATIONS?, PLEASE CIRCLE:

Allergy to Latex	Yes	No	Local Anesthetic (Novacaine)	Yes	No
Penicillin	Yes	No	Other Antibiotics	Yes	No
Sulfa Drugs (septra, bactrim, etc?)	Yes	No	Aspirin, Tylenol, Advil, Etc. (circle)	Yes	No
Barbiturates, Tranquilizers, Sleeping Pills	Yes	No	Sedatives	Yes	No

What happens when you take these medications?_____

Are you ALLERGIC to any OTHER MEDICATIONS? If yes, please list_____

ARE YOU <u>TAKING</u> ANY OF THE FOLLOWING MEDICATIONS? PLEASE CIRCLE:

Antibiotics	Yes	No	Anticoagulants (Blood Thinners)	Yes	No
Sulfa Drugs (Septra, Bactrim, etc)	Yes	No	Advil	Yes	No
Cortisone (Steroids, in last 2 years)	Yes	No	Sedatives/Anti-Anxiety Medication	Yes	No
Insulin or Orinase (Diabetic)	Yes	No	Digitalis or other Heart Medications	Yes	No
Nitroglycerin	Yes	No	Decongestants	Yes	No
Aspirin	Yes	No	Tylenol	Yes	No
Biphosphonates (Fosamax, Boniva, etc)	Yes	No			

***PLEASE LIST ALL MEDICATIONS YOU ARE TAKING*:**_____

_____

Please circle YES or NO if you are being treated, or have been treated for any of the following:

Yes	No	Used Phen-Phen	Yes	No	Ulcers/colitis
Yes	No	If so, had EKG?	Yes	No	Kidney dialysis
Yes	No	Recent Illness	Yes	No	Bruise Easily
Yes	No	Heart disease	Yes	No	Had Heart Surgery
Yes	No	Heart Attack	Yes	No	Asthma
Yes	No	Glaucoma	Yes	No	Hives
Yes	No	Angina	Yes	No	Emphysema
Yes	No	Frequent swollen ankles	Yes	No	Tuberculosis
Yes	No	Chest pain on exertion	Yes	No	Lung Disease
Yes	No	Stroke	Yes	No	Recent cough or cold
Yes	No	High blood pressure	Yes	No	Nose obstruction
Yes	No	Low blood pressure	Yes	No	Rheumatic fever
Yes	No	Bronchitis	Yes	No	Chemotherapy
Yes	No	Heart Murmur	Yes	No	Hay Fever
Yes	No	Mitral Valve Prolapse	Yes	No	Sinus Trouble
Yes	No	w/ regurgitation	Yes	No	Allergies
Yes	No	Congenital heart lesions	Yes	No	Cancer
Yes	No	Artificial Heart Valve	Yes	No	Radiation therapy
Yes	No	Heart Pacemaker	Yes	No	Arthritis / Rheumatism
Yes	No	Artificial Joints	Yes	No	Cortisone medication or ACTH
Yes	No	Blood Disease	Yes	No	Pain in jaw joints / TMJ
Yes	No	Anemia	Yes	No	Thyroid Disease
Yes	No	Bleeding tendencies	Yes	No	Glandular disease
Yes	No	AIDS / ARC / HIV+	Yes	No	Diabetes
Yes	No	Hepatitis A, B, C or other	Yes	No	Epilepsy
Yes	No	Infectious mononucleosis	Yes	No	Fainting spells or dizzy spells
Yes	No	Blood Transfusion	Yes	No	Cold sores
Yes	No	Liver disease / Jaundice	Yes	No	Active Herpes
Yes	No	Hemophilia	Yes	No	Venereal Disease
Yes	No	Kidney Trouble	Yes	No	Alcohol/ Drug Addiction Treatment
Yes	No	Psychiatric Care	Yes	No	Recreational Drug Use
Yes	No	High Cholesterol			
Yes	No	Osteoporosis			

Yes No Do you smoke? How many per day?_____

Yes No Are you on a special diet? What kind?_____

Have you been hospitalized in the past 5 years? Yes No

If yes, what was the problem?_____

Past Surgical History: _____

Are you presently under the care of a physician? Yes No

Doctor's Name / Address / Phone #/E-mail_____

_____

FAMILY HEALTH HISTORY

Dental infections and periodontal disease have been associated with a variety of medical conditions which can be hereditary. New research shows periodontal treatment can reduce the risk of heart disease, stroke, diabetes, pre-term birth, respiratory disease, and a person's overall health. Please circle all of the following that pertain to any of your blood relatives, i.e. grandparents, parents, aunts, uncles, siblings, cousins, etc. :

Periodontal Disease/ Periodontal Surgery	Arthritis	Cancer
Diabetes	Genetic Disease	Heart Disease
Hypertension	Osteoporosis	Bone Loss (Dental or otherwise)
General tooth or gum problems	Obesity	Artificial Joints

Other conditions/diseases that run in your family:

_____

_____

_____

FEMALES ONLY, PLEASE CIRCLE:

Are you Pregnant?	Yes	No
Trying to become Pregnant?	Yes	No
Taking Oral Contraceptives?	Yes	No

DENTAL HEALTH

Please circle YES or NO if you are being treated, or have been treated for any of the following:

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing and/or swallowing ability?

Have you ever had:

Yes No Orthodontic Treatment (Braces)
Yes No Oral Surgery (Extractions)
Yes No Periodontal Treatment
Yes No Your bite adjusted
Yes No A bite plate or other dental appliances

Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to get caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have an unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( )
Yes No Have missing teeth been replaced?
Yes No Do you have any soreness, pain, clicking or popping in the area in front of your ears?

Please circle your level of anxiety regarding dental procedures:

None 1 2 3 4 5 6 7 8 9 10 Extremely anxious

When did you last have your teeth cleaned before this appointment?_____
How long before that?_____
How often do you see your dentist?_____
How often and when do you brush your teeth?_____
Do you use: Hand toothbrush ( ) Electric toothbrush ( ) MI Paste ( )
What else do you use to clean your teeth at home? (Floss, toothpick, water pick, etc.)_____
How often?_____

CONSENT FOR TREATMENT

RISKS OF DENTAL PROCEDURES IN GENERAL: Dr. Stephen H. Munroe believes in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment as well as our financial policy. **Our financial policy is that fees are due before or at the time of service.**
For your convenience we accept VISA, MasterCard, American Express, Discover and Care Credit (HealthCare Credit Card). We do not 'carry' balances on patient accounts, without prior payment arrangements being made.
Many people think if they have dental insurance, it is the insurance company, which owes the doctor for their services. This is not the case. The dental insurance contract is between the patient and the insurance company. Therefore, the patient is responsible for the bill, regardless of the insurance company. As a courtesy to our patients, we will bill your insurance company; however, the responsibility for the payment will remain with you. In order for us to bill your insurance company you must supply us with complete information about your coverage including any necessary forms and group numbers.
Most dental insurance plans do not cover 100% of the cost of your treatment. Insured dental patients are expected to pay the estimated non-insurance portion at the time of service. If your insurance has not been paid within 90 days of treatment you will need to pay your account in full to this office and we will reimburse you when your insurance has paid.
An often-misunderstood term used by many insurance companies is Usual, Customary and Reasonable Fee Schedule (UCR). This is an arbitrary fee ceiling at which the insurance company will stop reimbursement. After this ceiling, coverage for a particular service will cease. Again, this has nothing to do with the fee we charged, but with the level of coverage negotiated by the policyholder. Our office can make no guarantee of the insurance estimate of payment. Delinquent accounts will be referred to a collection agency at the discretion of the office manager.
Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration of teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication prescribed and drugs administered may cause drowsiness, lack of awareness, and coordination (which can be influenced by the use of alcohol and other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work until recovered from their effects.

- I hereby authorize Dr. Stephen H. Munroe, D.D.S. and whomever he may designate to perform any dental treatment necessary and to administer emergency care as needed. I agree to the use of local anesthetic. I have been informed of possible complications of dental procedures.
- I authorize the performance of any laboratory, x-ray or other studies that may be used by Stephen H. Munroe, D.D.S., or his designated staff as deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Stephen H. Munroe, D.D.S., and his designated staff, to perform all recommended treatment mutually agreed upon by me.
- In order to receive treatment, I contract that if there are any differences of disagreements between Dr. Munroe, D.D.S., and myself, I will first present such differences or disagreements to Dr. Munroe in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the San Diego County Dental Society's peer review and agree to accept their resolution in lieu of pursuing remedies by way of litigation. In consideration of helping to keep costs of treatment and services as low as possible, I also understand that this agreement is binding on my heirs and other family members.

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS:

_____ I understand and agree that I am fully responsible for payment of all services rendered on my behalf or my dependents, regardless of any insurance coverage that I might provide. I further understand that any balances on my account after 60 days will be assessed a finance charge of 18% APR.

_____ I understand that the contract I have with my dental insurance company is between the insurance company and myself, and does not involve Dr. Munroe, but if I provide Dr. Munroe's office staff with complete information relating to my dental insurance, they will assist me by submitting my claims and interceding on my behalf. I authorize Stephen H. Munroe, D.D.S., and his staff to release information to my insurance company or companies including diagnoses, records, of any treatment or examinations rendered. I consent to have payments paid directly to Stephen H. Munroe, D.D.S., from my insurance company. All accounts with an insurance balance over **60 days** will be charged back to myself and I am responsible for paying the balance. If the office receives additional monies from the insurance company, we will promptly credit your account.

_____ **Our office requires 48-hour notice or you will be charged $50 per hour of appointment time. This means you must call 48 hours ahead of your scheduled appointment time if you wish to cancel or reschedule.**

Patient / Parent Signature:_____ Date:_____