(PLEASE PRINT)

Patient Information

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

Dental Insurance

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ 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(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ Date

______ Relationship to Patient

Phone Numbers

Home (____) ______ Work (____) ______ Ext ______ Cell Phone (____) ______

Spouse's Work (____) ______ Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

Dental History

Reason for today's visit ______

______

Former Dentist ______

City/State ______

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? ______

Dental Registration and History

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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

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
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 Glands	☐ 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 Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on 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 Care	☐ 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

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other ______________________

____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ______________ If so, what? ______________________________

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________________

Are you taking any new medications? ______________ If so, what? ______________________________

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

Smile Evaluation and Dental Anxiety Questionnaire

Smile Evaluation

1. Is there anything about your smile you do not like?
   ____
2. What are your goals for your oral health?(New smile or just keep it healthy, or both)____
   ____
3. Do you have any dentistry you DO NOT like? ____________________________________
4. What would you like to change most about your smile?
   ____

Dental Anxiety

1. If you had to "go to the dentist" tomorrow, how would you feel?
   a. I would look forward to it.
   b. I wouldn't care one way or the other.
   c. I would be uneasy.
   d. I would be afraid it would be unpleasant and painful.
   e. I would be very frightened of what the dentist might do.
2. When you are waiting in the dental office for your turn in the chair, how would you feel?
   a. Relaxed
   b. A little uneasy
   c. Tense
   d. Anxious
   e. So Anxious that I sometimes breakout in a sweat or almost feel physically ill.
3. When you are in the dentist's chair waiting while he gets the drill ready to begin working on your teeth, how do you feel?
   a. Relaxed
   b. A little uneasy
   c. Tense
   d. Anxious
   e. So anxious that I sometimes break out in a sweat or almost feel physically ill.
4. Imagine you are in the dental chair to have your teeth cleaned. While you are waiting the hygienist is getting out the instruments which she/he will use to clean your teeth around the gums, how do you feel?
   a. Relaxed
   b. A little uneasy
   c. Tense
   d. Anxious
   e. So anxious that I sometimes break out in a sweat or almost feel physically ill.

Mark A. Babbitt, DDS
3088 Telegraph Road, Suite C
Ventura, CA 93003

HIPPA Consent

I give Mark A. Babbitt, DDS and his staff (hereafter referred to as: the Practice) my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations (quality reveiws).

I have been informed that I may review the practices Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this Practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request.

I also understand that I may revoke this consent at any time by making a written request to do so, except for information already used or disclosed.

Signature: ____

Date: ____

Signature of representative: ____
Relationship to patient: ____

Mark A. Babbitt, DDS

3088 Telegraph Road Suite C
Ventura CA 93010
805-653-1775

Office Financial Policy

Dear Valued Patient,

Thank you for selecting our office as your dental health care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask.

Payment is due at the time services are rendered. We accept cash, personal checks, MasterCard, Visa, American Express, Discover Card as well as Care Credit and Citibank Health Card. We offer a 5% treatment room Reservation (cash or check) discount for fees paid **48** hours prior to the scheduled appointment on services that are over $500.00. We cannot offer a discount when using Care Credit or Citi Health Card, or a credit card. A 10% **senior courtesy** is given to our senior patients over the age of 65. We cannot offer a combination of the above mentioned discounts.

We will gladly help you process your insurance claim for your reimbursement as long as we have complete insurance information.

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

2. All charges are your responsibility whether your insurance pays us or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments are due at time of treatment.

4. We may ask you to assist us in collecting your insurance balance when your insurance company has not paid their portion in full after 30 days.

5. Balances over 90 days are subject to additional collection fees and interest charges of 1.5% per month. Returned checks will have additional amount of $50.00 charged to the account.

Please note that failure to notify us of a cancellation or to reschedule an appointment within 48 hours will subject you to a charge of $50.00. A **$50.00** Returned Check Fee will apply to those checks that do not clear the bank. Please call as soon as possible when you believe you cannot make your appointment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us as soon as possible so we can assist you in the management of your account.

Signed: ____ Date:____________