Lan Dao, DDS & Jane Refela, DDS
831 East Huntington Dr. Suite 201
Monrovia, CA 91016
626-359-8300
monroviadentalcare@gmail.com
www.monroviadentalcare.com

PATIENT INFORMATION

Last Name: _____ **First Name**: _____ Middle Initial: _____

Preferred Name: _____ Patient Is: Policy Holder ○ Yes ○ No

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell**: _____ Work: _____

Preferred to call: (please circle) Home Cell Work **Ok to Text?** ○ Yes ○ No Best time to call: _____ AM PM

Birth Date: _____ Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Other

Social Security: _____ **Email:** _____

Occupation: _____ Employer: _____

How did you hear about our office? Yelp Facebook Website Other: _____

Responsible Party or Policy Holder (don't fill this out if you're the patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Birth Date: _____ Social Security: _____ Relationship to this patient: _____

Dental History Questionnaires

Please answer each question by circling Yes or No

Would you like to straighten your teeth? _____ Yes No

Do you have a specific dental problem or complaint? Describe: _____ Yes No

Do you have dental examinations on a routine basis? If Yes, When was your last visit? _____ Yes No

Do you think you have cavities or gum disease? _____ Yes No

Do you brush and floss on a routine basis? How often? _____ Yes No

Do your gums ever bleed? Describe: _____ Yes No

Do you like your smile? Why? _____ Yes No

Do you want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you clench or grind? _____ Yes No

Have your past experiences in a dental office been positive? _____ Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent, or Guardian: _____ Relationship: _____ Date: _____

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HEALTH HISTORY

PATIENT NAME _____

Please answer each question by checking the appropriate box or circling Yes or No

Are you under a physician's care now? If Yes, please explain: _____ Yes No

Have you ever been hospitalized or had a major operation? If Yes, please explain: _____ Yes No

Have you ever had a serious head or neck injury? If Yes, please explain: _____ Yes No

Are you taking any medications, pills, or drugs? If Yes, please explain: _____ Yes No

Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? _____ Yes No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____ Yes No

Do you use tobacco? _____ Yes No

Do you use any recreational drugs (e.g., Marijuana, Cocaine) or controlled substances? _____ Yes No

Do you wear a cardiac pacemaker, or have you had heart surgery? If Yes, please explain: _____ Yes No

Are you allergic to any of the following: Penicillin, sulfa, codeine, aspirin, Latex? If Yes, please list: _____ Yes No

Female: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No If Yes, how many months? _____ Taking birth control pills? ○ Yes ○ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Renal Dialysis	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Herpes	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Angina	☐	☐	Epilepsy/Seizures	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Asthma	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Stomach Disease	☐	☐
Blood Disease	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Bruise Easily	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Heart Attack/Failure	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Chest Pains	☐	☐	Heart Murmur	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Cold Sores	☐	☐	Heart Pace Maker	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
Congenital Heart Defect	☐	☐	Heart Trouble/Disease	☐	☐	Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Hemophilia	☐	☐	Recent Weight Loss	☐	☐	DR. INITIAL: _____		

Patient Responsible for Fees & Assignment of Insurance Benefits: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on the date which services are provided. I hereby authorize that the payments from any insurance company due me be paid directly to this office. In the event of default in my payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees.

Responsible Party Signature: _____ Relationship _____ Date _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient or Guardian _____ Relationship _____ Date _____

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Our Office Policy

General

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our information and insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE PRIOR TO APPOINTMENT.

We accept Cash, Checks, Visa, MasterCard and Care Credit.

Regarding Insurance

Fees are estimates only, and are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

Usual and Customary Rates

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled, at least 2 business days (Monday-Thursday) in advance, our policy is to charge for missed appointments at the rate of $50.00 to the full amount of the scheduled visit. Please help us serve you better by keeping scheduled appointments.

Consent

I understand and agree to this Financial Policy

Patient Name (please print) _____

Patient/Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist to release health information identifying me [Including if applicable, information about HIV infection or AIDS, information about substance Abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Completed, existing, and proposed dental treatment, Dental x-ray information, Medical history, Treatment referral information, Insurance authorization and benefit breakdown, Account information, such as balances due, amounts paid, and insurance coverage

2. To whom may the information be released: Professional associates, partners and referring doctors, third party billing entities and insurance carriers

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): To enable dental services to be provided

4. Expiration date or event relating to the individual or purpose for the release: Term shall end upon termination of professional-patient relationship.

5. Restrictions on disclosure of my PHI as follows:
It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

Send this note to the office contact person listed at the top of this form.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name (please print): _____

Patient or Guardian/representative Signature: _____ Date: _____

Doctor Signature: _____ Date: _____