UNION
SQUARE
DENTAL
PRACTICE

450 Sutter Street, Suite 1326
San Francisco, California 94108
P: (415)693-9139
F: (415)693-9191
info@unionsquaredental.com

New Patient Form

Primary Information

Full Name_________________________________ Nickname____________________ Sex ☐F ☐M

Birthday______________________ Social Security Number_________________________________

Occupation________________________________ Employer _________________________________

Home Address____

Phone _________________________ ☐Home ☐Mobile Email______________________________

Business Address____

Insurance Information

Do you have dental insurance? ☐Yes ☐No

Primary Insurance
Name of Policy Holder____________________ ID/SSN___________________ DOB_____________

Insurance Co___________________ Group#____________ Relationship to Patient____________

Secondary Insurance
Name of Policy Holder____________________ ID/SSN___________________ DOB_____________

Insurance Co___________________ Group#____________ Relationship to Patient____________

Getting to Know You

Whom may we thank for referring you to our office?_______________________________________

Person to contact in case of emergency______________________ Relationship________________

Address_______________________________________ Phone Number_________________________

I hereby authorize payment to the above dentist of the group dental benefits I provided, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any and all charges, including those not covered by my insurance or by this authorization.

Signature of Patient____ Date____________________

Signature of Parent/Guardian_________________________________ Date____________________

Name of Parent/Guardian__________________________________ Relationship________________

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Health History Form

Full Name____ Date of Birth____________________

Are you in good overall health? ☐Yes ☐No

Have there been any significant changes in your health within the last year? If so, please explain:

____

Have you had serious illness, surgeries or been hospitalized within the past five years? If so, please explain: ____

Current physician or medical office name:____

Address: ____ Phone:____________________

Date of last physical exam:________________________

For women only, are you:

- Pregnant
- Nursing
- On birth control or taking hormones

Have you had or do you have any of the following? Please check all that apply.

- Heart Problems
- Cardiac Stent
- History of Infective Endocarditis
- Artificial Heart Valve
- Pacemaker
- Heart Attack or Stroke
- High or Low Blood Pressure
- Anemia or other Blood Disorder
- Prolonged Bleeding
- Pneumonia or Emphysema
- Tuberculosis
- Asthma
- Shortness of Breath
- Sleep Apnea
- Kidney Disease
- Liver Disease
- Hepatitis
- Thyroid Disorder
- Parathyroid Disorder
- High Cholesterol
- Diabetes I,II
- Digestive Disorder
- Acid Reflux
- History of Eating Disorder
- Herpes/Cold Sores
- HIV, AIDS
- Allergies/Hay Fever
- Autoimmune Disease
- Immunosuppresive Medication
- Psychiatric Disorder
- Epilepsy, Convulsions
- Neurological Disorder
- Head or Neck Injuries
- Tumor, Abnormal Growth
- History of Cancer
- Radiation/Chemo
- Contact Lenses
- Organ Transplant
- Osteoporosis

☐Please check this box if you do not have any of the above conditions.

List of all prescription or over the counter medications, drugs or supplements taken and reason

Drug________________ Purpose________________ Drug________________ Purpose________________

Drug________________ Purpose________________ Drug________________ Purpose________________

Drug________________ Purpose________________ Drug________________ Purpose________________

List any allergies to medications:____

Do you use tobacco products (smoke, vapor, snuff, chew)? ☐Yes ☐No

Do you use controlled substances (recreational drugs)? ☐Yes ☐No

Do you drink alcoholic beverages? If yes, how many drinks per week: ______________________

Do you have any conditions not listed above? ____

I certify that I have read and understand this form and have answered every question completely and accurately to the best of my knowledge. I will inform my dentist of any changes in my health and/or current medications. Further, I will not hold my dentist or any member of the staff responsible for any errors or omissions that I've made in completion of this form. I authorize the dentist to contact my physician as needed.

Signature of Patient, Parent or Guardian________________________________ Date___________

Signature of Dentist ____ Date ___________

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Dental History Form

What is the reason for your visit today?____________________

Date of last dental visit________ Last Dental Cleaning________ Last full-mouth x-rays_________

What was done on your last dental visit?____________________

How often do you brush your teeth?______________ How often do you floss?_______________

What other dental hygiene tools do you use at home?____________________

Previous Dentist's Name______________________________ Phone ________________________

Address ____

Are any of your teeth sensitive to:

Hot	☐Yes	☐No
Cold	☐Yes	☐No
Sweets	☐Yes	☐No
Biting or chewing	☐Yes	☐No

Have you noticed any:

Mouth odors	☐Yes	☐No
Bad taste in your mouth	☐Yes	☐No
Cold sores or oral lesions	☐Yes	☐No
Loose teeth or change in bite	☐Yes	☐No
Food stuck between teeth	☐Yes	☐No

If yes, which particular area?
____

Have you ever had:

Orthodontic treatment ☐Yes ☐No
If yes, what type______________________________
Oral surgery/extractions ☐Yes ☐No
Periodontal (gum) treatment ☐Yes ☐No
Teeth Bleaching ☐Yes ☐No
Evaluation for sleep apnea ☐Yes ☐No

Do you currently have/use:

Night guard	☐Yes	☐No
Orthodontic retainer	☐Yes	☐No
Sport guard	☐Yes	☐No
Sleep apnea appliance	☐Yes	☐No

Do you often:

Bite your lips or cheeks	☐Yes	☐No
Hold objects with your teeth	☐Yes	☐No
Drink carbonated drinks	☐Yes	☐No
Smoke/chew tobacco	☐Yes	☐No

Do you feel:

Satisfied with your smile	☐Yes	☐No
Uncomfortable smiling big	☐Yes	☐No
Nervous about dental treatment	☐Yes	☐No

If so, what concerns you most?
____

Have you ever had an upsetting dental visit?
If so, please explain:
____
____

Have you experienced any of the following (currently or previously): Check all that apply.

- ○ Mouth breathing while awake or asleep
- ○ Severe gag reflex
- ○ Acidic stomach or acid reflux
- ○ Bulimia
- ○ Bleeding gums
- ○ Pain/sensitivity while brushing or flossing
- ○ Injury or trauma to head or mouth

If yes, please explain______________________________

- ○ Clenching or grinding
- ○ Clicking or popping of the jaw
- ○ Pain (facial, jaw joints or near ear)
- ○ Difficulty opening/closing your mouth
- ○ Head, neck or shoulder aches
- ○ Sore neck or shoulder muscles
- ○ Tired jaw in the mornings

Is there anything you would like to change about the appearance of your teeth?
____

Signature of Patient, Parent or Guardian__________________________________ Date___________

Signature of Dentist ____ Date ___________

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Informed Consent

Treatment Consent
I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of dental need of.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon me to employ such assistance as required to provide proper care.

I agree to use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

Financial Consent
I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

In the event that payments are not received by the agreed upon dates and my account falls 60 days past due or more, I understand that my account is subject to be sent to a credit reporting collection agency.

Cancellation Policy
Your appointment time is reserved especially for you. In the event you need to change a scheduled appointment, we require two business days notice. This time allows us the opportunity to schedule another patient who may be waiting for care. If you cancel or reschedule an appointment without contacting our office within the required time frame, this will be considered a missed appointment and a $100 cancellation fee will be charged to your account which cannot be billed to your insurance company and will be your direct responsibility. No future appointments will be scheduled until the payment of this fee has been made.
Additionally if a patient is more than 20 minutes late for a scheduled appointment, we will consider this a missed appointment and the cancellation fee will be charged.

Signature of Patient, Parent or Guardian________________________________ Date___________

Name of Patient, Parent or Guardian __________________________ Relationship_____________