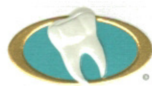

Patient Information

Today's Date ___________________

Patient Name: ______________________________________ (Last, First) _______________ (Preferred) Parent's name if minor ____________________

Birth date: ____/_____/_________ SS#: _____ -____-______ Driver's Lic or Other ID: _______________ Marital Status: ___________

Address: ____ (Street, Apt, City, State, Zip Code) E-mail:___________________________

Home Ph: (time to call): ( ) _________________ Work Ph: ( ) _________________ Cell Ph: ( ) _________________

Employer: ____ Occupation: ____

Person to notify in case of emergency: _________________________ Relationship ______________Phone: _____________________

How did you hear about us? ☐ Internet ☐ Yellow Pages ☐ Insurance Listings ☐ Word of mouth ☐ Friend: ___________________

Financial Policy

ON FEES AND PAYMENTS:
Payment is expected at the time of service. Fees are subject to change with prior notice before treatment. Balances remaining beyond 30 days from billing will have a late payment charge of $20 and accrue a monthly interest at a rate of 10% APR. There is a $35 processing fee for returned checks, and a $50 per hour fee for broken appointments without 48-hour notice. Co-payment is expected at the time of service. If you prefer not to wait in line after your appointment, please ask us about our VIP Express checkout option.

ON DENTAL INSURANCE:
We accept most PPO dental insurances. The insurance policy is an agreement between you (the patient, or patient's employer), and the insurance company, not between the insurance company and this office. It is the patient's responsibility to understand his/her insurance policy prior to treatment. Insurance benefits are subject to change based on condition of employment, change in benefit coverage or non-coverage, or change in patient status. If your insurance pays for an alternate benefit, you will be responsible for the difference between the fee for the actual procedure and the alternate procedure fee. If your insurance does not pay in full for any reason, you will be responsible for the remaining balance of the treatment.

I take responsibility for payment of all services rendered on my behalf or my dependents regardless of any insurance involvement. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related legal fees.

____ _________________

Signature of Patient / Guarantor if minor **Date**

Assignment of Benefits and Authorization Release

I hereby authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct my insurance carrier to make out the check to me and mail as follows:

Camino Dental Group • 1328 W. El Camino Real Suite #1, Mountain View, CA 94040

I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

____ _________________

Signature of Patient / Guarantor if minor **Date**

Dental History

Date of last dental visit :

Services performed:

Date of last full mouth x-rays:

Please check all that applies:
- ❑ Bleeding gums
- ❑ Sensitive teeth
- ❑ Toothache
- ❑ Wisdom teeth removal
- ❑ Orthodontic Treatment (braces)
- ❑ Dental Implants
- ❑ Gum Surgery
- ❑ Dental complications
- ❑ Wearing (please circle) denture mouth guard retainers

Dental products used:
- ❑ Power toothbrush _____________
- ❑ Floss
- ❑ Water irrigator (Waterpik)
- ❑ Perioaid/ gum stimulator
- ❑ Proxy brush
- ❑ Mouth rinse _________________
- ❑ Whitening products ___________

Please check if interested:
- ❑ Whitening teeth
- ❑ Straightening teeth
- ❑ Dental Implants
- ❑ Porcelain Veneers/Crowns

Please describe any current dental problem