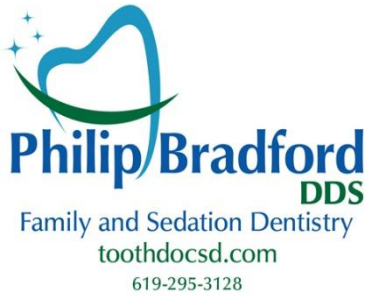

Patient Information

PatientName_____

Preferred Name_____ Preferred Pronouns_____

Address_____ Zip code_____

Telephone: Home_____Cell_____

Employer: _____

Driver's License Number: _____ Date of Birth_____

Spouse/Partner: _____

Whom can we thank for referring you? _____

Dental Insurance Information

Policy Holder Name & Date of Birth _____

Policy Holder ID # or SSN _____

Insurance Company & Group #_____

Insurance Mailing Address_____

Financial Guidelines

As a courtesy to you, we will complete and file insurance forms for your dental treatment.
You are responsible for verifying benefits and coverage percentages.
The estimated amount the insurance company will not cover is due at time of treatment unless prior arrangements are made. Charges for patients without insurance coverage are due at the time of treatment unless prior arrangements are made. Charges not paid within 60 days are subject to a finance charge of 1.50% per month (18% annual rate). **Initial** ___

Authorization and Release

I authorize the release of any information to third party payors and/or health practitioners. I authorize payment from my insurance company to be issued directly to Dr. Bradford. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf. I certify I have read and understand the above information and the information I have provided is accurate. **Initial** _____

Notice of Privacy Practices

I have had the opportunity to read Philip Bradford's Notice of Privacy Practices. I understand that I will receive a copy upon request. **Initial** _____

Electronic Communication

I agree that Philip Bradford DDS may communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: 619-295-3128. **Initial** _____

Email Address (print clearly): _____

Signature: _____ Date: _____

Philip Bradford
DDS
Family and Sedation Dentistry
toothdocsd.com
619-295-3128

Dear Patients,

We realize your time is very valuable and out of respect for that we never double book appointments and strive to follow the schedule to the best of our ability.

It is our office policy to require at least 24-hour notice if an appointment is to be changed or cancelled. Changes made without 24-hour notice or missed appointments will incur a $75 charge.

As a courtesy, we will give a reminder call, text or email two days before the day before the appointment.

Our answering machine is always on for calls made when the office is closed.

Thank you for letting us care for your oral health. By minimizing schedule mishaps, we can maximize our time spent caring for you.

Thank you very much for your cooperation.

Philip Bradford DDS and Team

Signature_____ Date_____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____Date of Birth: ___/____/_____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good? If NO, explain: _____

2. Yes / No Has there been a change in your health within the last year? If YES, explain: _____

3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

If YES, explain: _____

4. Yes / No Are you being treated by a physician now? If YES, explain: _____

Date of last medical exam? _____ Reason for exam: _____

5. Yes / No Have you had problems with prior dental treatment? If YES, explain: _____

Date of last dental exam: _____ Name of last treating dentist: _____

6. Yes / No Are you in pain now? If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Frequent vomiting	Yes / No Blood in stools
Yes / No Fainting spells	Yes / No Sinus problems	Yes / No Diarrhea or constipation
Yes / No Jaundice	Yes / No Recent significant weight loss	Yes / No Frequent urination
Yes / No Dry mouth	Yes / No Fever	Yes / No Difficulty urinating
Yes / No Excessive thirst	Yes / No Night sweats	Yes / No Ringing in ears
Yes / No Difficulty swallowing	Yes / No Persistent cough	Yes / No Headaches
Yes / No Swollen ankles	Yes / No Coughing up blood	Yes / No Dizziness
Yes / No Joint pain or stiffness	Yes / No Bleeding problems	Yes / No Blurred vision
Yes / No Shortness of breath	Yes / No Blood in urine	Yes / No Bruise easily

Other: _____

III. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Herbal supplements	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, when: _____	Yes / No Anti-Depressants Yes / No Weight loss medications	Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Please list all prescription medications: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Codeine or other opioids	Yes / No Metal
Yes / No Valium or sedatives	Yes / No Penicillin or other antibiotics	Yes / No Local anesthetic
Yes / No Nitrous oxide	Yes / No Food	

Others:_____

V. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Tuberculosis
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Hardening of arteries	Yes / No Liver disease	Yes / No High blood pressure
Yes / No Kidney or bladder disease	Yes / No Eye disease	Yes / No Stroke
Yes / No Seizures	Yes / No Cosmetic surgery	Yes / No Transplants
Yes / No Eating disorders	Yes / No Sexual transmitted disease	Yes / No Emphysema or other lung disease

Other: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Y/ N Are you or could you be pregnant? If YES, what month? _____Y / N Are you nursing? Y / N Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: _____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Physician's Name: _____Phone Number: _____

I authorize the dentist to contact my physician.

Patient's Signature:_____ Date:_____

Whom would you like us to contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) _____Date: _____

Signature of Dentist:_____Date_____