Welcome to Olive Dental Care

Dr. Sumeet Pannu D.D.S
3040 Park Ave. Suite H
Merced, CA 93548

Today's Date_____

PATIENT INFORMATION (Confidential)

Birth Date_____/_____/_____

Name_____ _____ Female _____Male

SS# _____-_____-_____Home/Primary Phone# _____Cell# _____

Address _____ City _____ ST _____ Zip Code_____

Please **circle** – Minor Single Married Separated Divorced Widowed

Employer Name _____Address _____Work # _____

Email Address _____ Driver's License Number _____

Spouse / Parents Name _____**How did you hear about our office?** _____

Emergency Contact _____*Relationship* _____*Phone #* _____

What days and time works best for you?_____

RESPONSIBLE PARTY (If different than above)

Name _____ Relationship to patient _____
Address _____City _____ST _____ Zip code _____
Drivers license Number _____Birth date _____/_____/_____ SS# _____
Employer Name _____Address _____Work # _____

DENTAL INSURANCE INFORMATION

Name of Subscriber _____ Relationship to Patient _____
Birth date insured ___/_____/_____ ID#/SSN# _____-_____-_____ Union/local # _____
Name of Employer _____ Address _____ Phone # _____
Insurance Name _____ Group # _____ Group Name _____
Address _____ City _____ ST ___ Zip Code _____
Phone Number _____

Do you have additional Dental Coverage? *YES / NO If yes, complete the following;*

Name of insured _____ Relationship to Patient _____
Birth date insured _____ SS# _____ Union/local # _____
Name of Employer _____ Address _____ Phone # _____
Insurance Name _____ Group # _____ Group Name _____
Address _____ City _____ ST ___ Zip Code _____
Phone Number _____

Medical History: (Patient Name)_____

Physician's Name _____Office Phone _____Last seen_____

1. Are you under medical treatment now? **YES / NO** If yes, what? _____
2. Have you ever been hospitalized for surgery/serious illness within the last 5 years? **YES/NO** If yes, why? _____
3. Are you taking any medicines including non-prescription medicine? **YES / NO**
4. Have you ever taken Phen Phen / Redux? **YES / NO**
5. Do you use tobacco? **YES / NO**
6. Do you use controlled substance **YES / NO**
7. Are you wearing contact lenses **YES / NO**

8. **Are you allergic to, or had any reaction to the following:**

Local Anesthetics	**YES / NO**	Iodine	**YES / NO**
Penicillin	**YES / NO**	Any metals	**YES / NO**
Other Antibiotic	**YES / NO**	Sedatives	**YES / NO**
Sulfa Drugs	**YES / NO**	Aspirin	**YES / NO**
Barbiturates	**YES / NO**	Latex Rubber	**YES / NO**
		Other Allergy	_____

9. Do you have or have had any of the following? (Circle 'Yes' or 'No')

High Blood Pressure	Y / N	Cancer	Y / N	Allergies (Seasonal /Food)	Y / N
Low Blood Pressure	Y / N	Leukemia	Y / N	Thyroid Problem	Y / N
Heart Disease	Y / N	Radiation Therapy	Y / N	Tuberculosis	Y / N
Heart Attack	Y / N	Recent Weight Loss	Y / N	Emphysema	Y / N
Stroke	Y / N	Anemia	Y / N	Respiratory Prob	Y / N
Mitrol Valve Prolapse	Y / N	Liver Disease	Y / N	Arthritis	Y / N
Angina	Y / N	Diabetes	Y / N	Glaucoma	Y / N
Heart Murmur	Y / N	Hepatitis A, B or C	Y / N	Artificial Joints	Y / N
Pace Maker	Y / N	Epilepsy/Seizures	Y / N	Joint/Hip Replacement	Y / N
Rheumatic Fever	Y / N	Kidney Disease	Y / N	Stomach Troubles	Y / N
Sleep Apnea	Y / N	Nervous Disorder	Y / N	HIV/Aids	Y / N
Swollen Ankles	Y / N	Mental Disorder	Y / N	Sexually Trans Disease	Y / N

10. Women Only:
a. Are you pregnant or think you may be pregnant? **YES / NO**
b. Are you nursing? **YES / NO**
c. Are you taking Birth Control Pills? **YES / NO**

Patient Dental History

Name and Location of Previous Dentist? _____Date last exam? _____

1. Do your gums bleed when brushing / flossing? **Y / N**
2. Are your teeth sensitive to hot/cold? **Y / N**
3. Are your teeth sensitive to sweet/sour foods? **Y / N**
4. Are you having pain with any teeth? **Y / N**
5. Do you have any sores/lumps in your mouth? **Y / N**
6. Have you had any head/neck/jaw injuries? **Y / N**
7. Have you ever experienced any of the following;
Clicking **Y / N**
Pain(joint, ear, side of face) **Y / N**
Difficulty opening/closing **Y / N**
Difficulty in chewing **Y / N**
8. Do you have frequent headaches? **Y / N**
9. Do you clench / grind your teeth? **Y / N**
10. Do you bite your lips/cheeks? **Y / N**
11. Have you ever had a difficult extraction in the past? **Y / N**
12. Have you ever had any prolonged bleeding following extractions? **Y / N**
13. Have you ever had Braces? **Y / N**
14. Do you wear dentures/partials? **Y / N**
15. Have you ever received Oral Hygiene Instructions? **Y / N**
16. Do you like your smile **Y / N**

Authorization and release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such treatment or examination rendered to my child or me during the period of such dental care to third party payors and or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ X_____ _____
Signature of patient or parent if minor *Dr. Signature* *Date*

Welcome to Olive Dental Care

Thank you for choosing Olive Dental Care for your dental needs. We are sure you will be comfortable here with us. In order for us to assure that your experience is a pleasant one, we do ask that you read and understand following:

Office Policy

- **If you need to change your appointment, we require 48 hours notice. Failure to do so may jeopardize the scheduling of future appointments and will incur a $25.00 missed appointment fee; that must be paid prior to the next visit.**
- We require notification if there is **any changes in your insurance, address, or phone number.** Failure to do so may delay payment, causing you to have to pay out of pocket. If we are not able to contact you by phone, due to the phone being disconnected or you no longer live there we may give your appointment away.
- **Treatment of Minor Patients under the age of 18 must be accompanied by a parent and/or legal guardian for their NEW/CHECK-UP appointments and other visits where on-going treatment must be authorized. For on-going treatment, when consent has already been obtained, a responsible adult with a written consent from parent or legal guardian may accompany the patient. The accompanying adult must be in the building during the entire appointment in case of an emergency. Exceptions are granted by law to emancipated minors. An "emancipated minor" is one who is not dependent upon the parent(s) for support, or is a parent, or is or has been married.**
- We ask that you arrive promptly for your scheduled appointment time. **Failure to do so may result in having to be rescheduled.**
- **If we get NO ANSWER when confirming for your appointments scheduled, we have the right to schedule another patient who is in need of an appointment. It is your responsibility to confirm appointments.**

Financial Policy

- All charges incurred are your responsibility. **Payment is due the day the service is rendered**. If after treatment, you incur a balance, payment requested within 30 days or your account may be turned over **to a collection agency.**
- We charge 18% finance charge on balances over 30 days.
- We charge $25.00 returned check fee, plus the original amount of the check.
- We accept cash, all major credit cards. All checks will be converted to electronic debit the same day.

Assignment of Benefits

- **We require all co payments to be paid the day services are rendered**.
- We will complete insurance forms and submit claims on your behalf, although we do not accept responsibility for the outcome of the transaction. This is done as a courtesy. This is in no way eliminates your obligation for the charges incurred.
- **We do not guarantee that your insurance company will pay for the treatment you have received**. You are contracted with your insurance company and we will not enter into a dispute with your Insurance Company over a claim. We will however provide necessary documentation to the insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- Most insurance companies will pay within 30-60 days from the time if billing, If the claim is not paid within that time you will be asked to pay the balance in full.

We require your co-payment/fee the day the service is provided to you. Our office accepts these types of payment options.

Cash Debit/Credit Check (electronically deposited-same day) Care Credit Card

I have read and understand the above terms and conditions. I authorize my dental insurance company to pay my dental benefits directly to Olive Dental Care.

Signature **Date**