



<http://www.delaramadental.com>

[info@delaramadental.com](mailto:info@delaramadental.com)

**Confidential Patient History Form**  
*(Please fill out completely)*

Name \_\_\_\_\_ Date \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_ ZIP \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail address \_\_\_\_\_

What is the best way to reach you? (Circle top 2)      Call    Text    Postal Mail    E-Mail

Are you:      A Minor      Single      Married      Divorced      Widowed      Separated

If Student, Name of School/College \_\_\_\_\_ Full Time    Part Time

Patient or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City & State \_\_\_\_\_ ZIP \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party & Insurance Information**

Name of Person Responsible for this Account (Insured) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN# \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

What is Your Deductible Amount \_\_\_\_\_ Maximum Annual Benefit \_\_\_\_\_

Do You Have Any Additional Dental Coverage?    Yes    No    (If Yes, please write on back of form)

## **Patient Medical History**

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Please circle "yes" or "no" to indicate if you have had any of the following:

|                                |     |    |                             |     |    |                         |     |    |
|--------------------------------|-----|----|-----------------------------|-----|----|-------------------------|-----|----|
| AIDS/HIV                       | Yes | No | Hepatitis Type_____         | Yes | No | Radiation /Chemotherapy | Yes | No |
| Artificial Heart Valves/Joints | Yes | No | Herpes                      | Yes | No | Respiratory Disease     | Yes | No |
| Arthritis                      | Yes | No | High Blood Pressure         | Yes | No | STD                     | Yes | No |
| Asthma                         | Yes | No | Jaw Pain                    | Yes | No | Sinus trouble           | Yes | No |
| Cancer                         | Yes | No | Kidney and/or Liver Disease | Yes | No | Stroke                  | Yes | No |
| Cortisone Treatments           | Yes | No | Mitral Valve Prolapse       | Yes | No | Swollen Neck Glands     | Yes | No |
| Chest Pain                     | Yes | No | Heart Murmur                | Yes | No | Thyroid Problems        | Yes | No |
| Diabetes                       | Yes | No | Pacemaker                   | Yes | No | Tuberculosis            | Yes | No |
| Epilepsy                       | Yes | No | Prolonged Bleeding          | Yes | No | Tumor on Head/Neck      | Yes | No |
| Fainting                       | Yes | No | Psychiatric Care            | Yes | No | Ulcers                  | Yes | No |

Please list any medications you are currently taking, how much & for what condition: \_\_\_\_\_

Are you allergic to:

\_\_\_\_\_

Aspirin                      Local Anesthetic                      Sleeping Pills

Pharmacy Name & Phone \_\_\_\_\_

Penicillin                      Codeine                      Sulfa

Do you currently take drugs for Osteoporosis?

Iodine                      Any Metal                      Latex Rubber

Yes    No    Example: Fosomax (Alendronate Sodium)

Other \_\_\_\_\_

Do you currently see a chiropractor or cranio-sacral therapist?    Yes    No

Do you currently suffer from any of the following conditions? (Circle all that apply)

Headaches                      Ear Aches                      Teeth Grinding                      Sleep Apnea or Snoring

Migraines                      Sore Jaw or Face Muscles                      Jaw Clenching                      TMJ or TMD Pain

Neck Pain or Stiffness                      Stiff Upper or Lower Back                      Ringing Sound in Ears                      Vertigo or Dizziness

Are you currently being treated for any of these conditions?    Yes    No

If you answered "NO", would you like to Dr. Dela Rama to discuss possible remedies for these conditions?

Yes    No

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DOCTOR'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Patient Dental History

Previous Dentist & Location \_\_\_\_\_ Date of Last Appt \_\_\_\_\_

1. Are your teeth sensitive to:

|                  |     |    |
|------------------|-----|----|
| Heat?            | Yes | No |
| Cold?            | Yes | No |
| Sweets?          | Yes | No |
| Biting Pressure? | Yes | No |

2. Does food constantly get stuck between certain teeth in your mouth?

Yes No

3. Are you dissatisfied with the way your teeth look?

Yes No Example: *color, shape, spaces, crowding*

4. Do you have fillings that show in your front teeth?

Yes No Does it bother you? Yes No

5. Do you have any fillings that show when you smile?

Yes No Does it bother you? Yes No

6. Do you want to replace your mercury amalgam fillings with a more natural, tooth-colored restoration instead?

Yes No

7. Have you ever had any teeth removed?

Yes No

8. How long have these teeth been missing? \_\_\_\_\_

9. Do your gums bleed when brushing?

Yes No

10. Has your former dentist/hygienist ever taught you how to brush your teeth?

Yes No

11. Do you ever avoid any part of the mouth while brushing?

Yes No Why? \_\_\_\_\_

12. Do you have an unpleasant taste or odor in your mouth?

Yes No

13. Do you smoke or use smokeless tobacco?

Yes No

14. Do you snack between meals on sweets or chew gum?

Yes No

15. How often do you brush your teeth? \_\_\_\_\_

16. How often do you floss? \_\_\_\_\_

(Please be honest, we can tell if you aren't!)

17. Do you want to learn to control dental disease and retain your teeth?

Yes No

18. Has fear of discomfort kept you from regular dental visits?

Yes No

19. When was your last dental appointment? \_\_\_\_\_

20. What did you have done? \_\_\_\_\_

21. How long since your last *thorough* examination with *full mouth x-rays*? \_\_\_\_\_

22. What prompted you to seek dental care at this time?

\_\_\_\_\_

\_\_\_\_\_



980 King Drive, #1 King Plaza Center  
Daly City, CA 94015

(650) 878-0651 | (650) 878-9575 fax  
www.delaramadental.com

## Informed Consent for Use & Disclosure of Health Information

### Section A: Patient Giving Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient #: \_\_\_\_\_ SSN: \_\_\_\_\_

### Section B: To The Patient – Please Read The Following Statements Carefully

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dela Rama Dental Care  
Telephone: (650) 878-0651 Fax: (650) 878-9575  
1 King Plaza Center  
Daly City, CA 94015

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### Signature

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**



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## Informed Consent for Use Of Images & Radiographs

### Section A: Patient Giving Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### Section B: To The Patient – Please Read The Following Statements Carefully

**Purpose of Consent:** Our office normally takes digital intraoral photographs and radiographs (x-rays) for our use in diagnosis, treatment planning, and patient education. Images are saved on our secure office server and associated with your digital chart. However, from time to time, Drs. Dela Rama and/or Garcia use images for educational or marketing purposes.

‘Educational purpose’ is defined as continuing education meetings, discussions with other dentals/specialists regarding treatment, or dental school lectures. ‘Marketing purpose’ is defined as printed images in our office to show “before and after” images of treatment; as well as on the office’s website. Images will be strictly of teeth and/or smiles, and at no time will your identity be revealed if your images are used; all HIPAA rules and regulations apply.

**Full Face Images:** If a full face image is to be used, and your identity would be revealed either for Educational or Marketing purposes, Drs. Dela Rama or Garcia will provide a separate consent for these purposes.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. You may obtain a copy of this Consent, including any revisions of this Consent, at any time by contacting:

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Telephone: (650) 878-0651 Fax: (650) 878-9575  
1 King Plaza Center  
Daly City, CA 94015

**Right to Revoke:** You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact listed above.

### Signature

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use my images for educational purposes as defined above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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## Insurance, Financial & Appointment Cancellation Agreement

\_\_\_\_\_(initials)\_\_\_\_\_ I certify that I and/or my dependant(s) are covered by insurance with \_\_\_\_\_(name of insurance company(ies))\_\_\_\_\_ and assign directly to **Drs. Dela Rama or Garcia** all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signatures on all insurance forms.

\_\_\_\_\_(initials)\_\_\_\_\_ The above named doctors may use my and/or my dependant(s) health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_(initials)\_\_\_\_\_ I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are financially responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient.

\_\_\_\_\_(initials)\_\_\_\_\_ In the event of non-payment by an insurance company or by a 3<sup>rd</sup> party collections agency; Drs. Dela Rama & Garcia are NOT responsible for handling any disputes between occupational human resource departments, their insurance companies, or their collection agencies.

\_\_\_\_\_(initials)\_\_\_\_\_ I understand that filing a claim with my insurance company is a **COURTESY** provided by **Drs. Dela Rama or Garcia**, and not a **REQUIREMENT** of their dental office. Even though Drs. Dela Rama & Garcia do file claims with my insurance, it does not relieve me from my financial responsibility for the payment of all charges.

\_\_\_\_\_(initials)\_\_\_\_\_ I understand that every appointment with Dr. Dela Rama or Garcia usually involves many preparatory steps by the doctors and staff, both mentally and physically. In addition, making appointments for long procedures and then failing to show up without excuse deprives another patient of the doctor's time that they desperately need. I agree that a 24-hour advance notice either in person, on the phone, or voice message is required for cancellations of ALL appointments. Any cancellations or failures to appear at my appointment that do not meet the advance cancellation policy will be subject to a \$75 fee per appointment. All treatments will not resume on the patient until they pay their delinquency fees in full.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian (if under 18)

\_\_\_\_\_  
Date