Michael Green DDS, 2821 Eastern Ave., Suite #5, Sacramento, CA 95821

NAME _____

Circle

YES NO 1. Are you having pain or discomfort at this time?
YES NO 2. Do you feel very nervous about having dental treatment?
YES NO 3. Have you ever had a bad experience in the dental office?
YES NO 4. Have you been a patient in the hospital during the past two years?
YES NO 5. Have you been under the care of a medical doctor during the past two years?

Physician's Name _____

Address _____ Phone # _____

YES NO 6. Have you taken any medicine or drugs during the past two years?
YES NO 7. Are you now taking any medication, drugs or pills?

If yes, please list: _____

YES NO 8. Are you allergic to have you reacted adversely to any of the following medications?

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)

YES NO 9. Are you aware of being allergic to any other medications or substance?

If yes, please list: _____

10. Circle any of the following which you have had or have at present

Y N Heart Failure	Y N Kidney Trouble	Y N Arthritis	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Heart Disease or Attack	Y N Ulcers	Y N Rheumatism	
Y N Angina Pectoris	Y N Cosmetic Surgery	Y N Cortisone Medicine	Y N Cold Sores Fever Blisters
Y N High Blood Pressure	Y N Emphysema	Y N Glaucoma	Y N Epilepsy or Seizures
Y N Heart Murmur	Y N Cough	Y N Pain in Jaw Joints	Y N Fainting or Dizzy Spells
Y N Rheumatic Fever	Y N Tuberculosis(TB)	Y N A.I.D.S.	Y N Nervousness
Y N Congenital Heart Lesions	Y N Asthma	Y N Hepatitis A(infectious)	Y N Psychiatric Treatment
	Y N Scarlet Fever	Y N Bisphosphonates	Y N Are you allergic to any metals (i.e.nickle?)
Y N Sickle Cell Disease	Y N Hepatitis B(serum)	Y N Liver Disease	
Y N Artificial Heart Valve	Y N Sinus Trouble	Y N Bruise Easily	Y N Have you had a skin reaction to any kind of jewelry?
Y N Heart Pacemaker	Y N Allergies or Hives	Y N Yellow Jaundice	
Y N Heart Surgery	Y N Diabetes	Y N Blood Transfusion	
Y N Artificial Joints (Hip,Knee)	Y N Thyroid Disease	Y N Drug Addiction	Y N Latex Gloves Allergy
Y N Mitro Valve Prolapse	Y N X-ray/Cobalt Treatment	Y N Hemophilia	
Y N Stroke	Y N Chemotherapy	Y N Anemia	

YES NO 11. Has your medical doctor ever said you have a cancer or tumor?
YES NO 12. Do you have any disease, condition, or problem not listed?

FOR WOMEN ONLY:

Are you pregnant? ___Yes ___No If yes, what month?_____Are you taking birth control pills? ___Yes ___ No

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ABOVE INFORMATION IS TRUE

Patient Signature/Parent or Guardian _____ Date ____/_____/_____

Patient Name Printed _____ Date ____/_____/_____

CONSENT:

The undersigned hereby authorized Doctor to take X-ray, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient)_____
And further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 %finance charge (21%annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____Date_____Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment at the office of Michael L. Green D.D.S., Inc. is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need a second opinion.
  (Include any other examples of situations where Protected Health Information may be shared.)

We at the office of Michael L. Green D.D.S., Inc. are committed to obeying all Federal, State and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer Connie at (916)483-7354.

I have read and understand the above Notice of Privacy Practices.

Signed_____ Date_____
(Patient or Legal Guardian)

☐ I consent to the dental practice using my cell phone number to (choose one or both):

☐ Call regarding treatment, insurance, and my account.

☐ Text regarding appointments and to call regarding treatment, insurance, and my account.

In understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ - _____ (Initials) _____

MICHAEL L. GREEN D.D.S.
2821 EASTERN AVE., STE.5
SACRAMENTO, CA 95821
916/483-7354

GET ACQUAINTED QUESTIONNAIRE

In order for us to better serve you; please fill in the following information completely: (complete 2 pages)

Patient's Name_____ Date of Birth __/___/___ M __ F __ Phone _____

Residence Address _____ City _____ Zip _____

Cell Phone: _____ Occupation and Employer _____ Phone_____

Business Address/School_____

__Single __ divorced __ Married (Name of Spouse
__Widow __ Separated __ Child or Parents) _____

Name and ages of
Children in the Family _____

Former Dentist _____ Date of last Dental Visit _____

Whom may we thank for referring you to this office? _____

Person responsible for payment of account _____ Number _____
Social Security

Street Address _____

Place of Employment _____ Phone _____

*Please complete the following information ONLY if patient is covered by Dental Insurance:

Name of Person Social Security
Carrying Insurance _____ Number _____

Name and address of Insurance Co. _____

Group Plan _____ Date of Birth ____/____/____

Is patient covered by another insurance plan? ___ No ____ Yeas
If yes: Name of person Social Security
Carrying insurance _____ Number _____
Last First

Name and Address of Insurance Co. _____

Group Plan _____ Date of Birth ____/____/____

For your benefit, a thorough examination, frequently including dental x-rays and diagnostic models of your mouth, is necessary before an intelligent and efficient analysis of your dental problems can be made. The assistants at the front desk can advise you of the fees for these services.

After a thorough diagnosis, your dental needs and problems will be discuss with you. Should you choose to place the care of your dental health with us, please be assured that the most thorough, conscientious service will be dedicated to this trust. All Facilities and personnel of this office are expressly here to serve you and your health.