Almaden Dental Associates
Family and Aesthetic Dentistry

Meng Syn DDS   Regina Gray DDS   Olga Belova DDS

ABOUT YOU

Today's Date: ______________________ Email address: ______________________

Name (Last, First Middle): ______________________ I prefer to be called: ______________________

☐ Male ☐ Female   ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐Separated

Birthday: __________ Age: ____ Social Security #: ______________ Drivers Lic: ______________

Home Address: ______________________ City: __________ State: ______ Zip: ______

Home Phone #: (____) ______________ Mobile: (____) ______________ Work: (____) ______________

When and Where are best times to reach you? ______________ Whom may we thank for referring you? ______________

Other family members seen by us: ______________________

Employer: ______________ How long there: ________ Occupation: ______________

Employer's address: ______________________

Person Responsible for Account if other than yourself

Name: ______________ Relation: ________ Home Phone #: ________ Social Security #: ________

Employer: ______________ Work Phone: ________ Ext.: ______ Drivers Lic.: ________

Billing Address: ______________________
Street City State Zip

SPOUSE or PARTNER INFORMATION (if included in insurance)

Name:	Birthday:	Social Security #:
Employer:	Work Phone #: Ext.:	Driver's Lic #:

INSURANCE INFORMATION

Primary Dental Insurance   Dental Coverage ☐Yes ☐No ☐Unsure   Orthodontic Coverage ☐Yes ☐No ☐Unsure

Insurance Co. Name: ______________ Phone Number: ______________ Group Number (Plan, Local or Policy#): ______________

Insurance Co. Address: ______________________
Street City State ZIP

Insured's Name: ______________ Insured's SS#: ______________ Insured's Birthday: ______________ Relation: ________

Insured's Employer: ______________ Employer's Address: ______________________
Street City State Zip

Secondary Dental Insurance   Dental Coverage ☐Yes ☐No ☐Unsure   Orthodontic Coverage ☐Yes ☐No ☐Unsure

Insurance Co. Name: ______________ Phone Number: ______________ Group Number (Plan, Local or Policy#): ______________

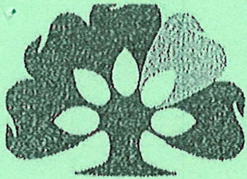
Insurance Co. Address: ______________________
Street City State ZIP

Insured's Name: ______________ Insured's SS#: ______________ Insured's Birthday: ______________ Relation: ________

Insured's Employer: ______________ Employer's Address: ______________________
Street City State Zip

I certify that I am covered by ______________________ Insurance Co. and I assign directly to Dr. ______________________ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________   ______________________
Signature   Date



Almaden Dental
ASSOCIATES

Almaden Dental Associates

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Meng Syn DDS
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(408) 224-0404
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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 Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	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	Yes / No Sinus problems

Other: ______________________________

III. 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
Type/ Date of surgery: ______________		
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexually transmitted disease
Yes / No Pacemaker		
Date implanted: ______________		
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 Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: ____________________

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

Others: ____________________

V. 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 Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Antidepressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Herbal supplements
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: ____________________

Please list all prescription medications: ____________________

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

Yes / No Are you or could you be pregnant? If YES, how many months? ____________________

Yes / No Are you nursing?

Yes / No 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 Have you tested positive for COVID-19?
If YES, date of positive test result: ____________________

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?
If YES, what are these symptoms or effects? ____________________

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?
If YES, please list ____________________

If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions 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.

I authorize the dentist to contact my physician.

Patient's Signature: ____________________ Date: ____________________

Physician's Name: ____________________ Phone Number: ____________________

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

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

ALMADEN DENTAL ASSOCIATES

REGINA GRAY DDS MENG SYN DDS
OLGA BELOVA DDS

Dental Insurance

With health care reform, and the ever changing economy, we are seeing many changes occurring in dental insurance coverage as employers try to save money by modifying plan coverages. It has become virtually impossible to keep up with all the plans and changes, making it a daily challenge to provide proper information and customer service to patients. Compounded by changes in coverage due to shifts in employment, divorces, and unemployment create an environment of confusion for those patients who do not make every effort to completely understand their current benefits, eligibility, and yearly requirements. Dental insurance companies can have many different policies, with varying requirements depending on the company. This requires a tremendous amount of time on the part of dentists and their office teams to communicate with insurance companies, file all the proper data, acquire predetermination information when required and address a myriad of other factors. Ultimately, it is the responsibility of the patient to confirm all estimates of coverage, eligibilities, and yearly limitations since if any mistakes are made, you the patient will be ultimately responsible for payment. Our office renders services not based on insurance coverage but by need, urgency, and consent. However, our office strives for accuracy and we work with your dental insurance companies to provide you with as accurate information as we can above and beyond our effort to provide you with excellent and timely dental care. Our quotes are not a guarantee of your insurance companies' coverage, and are merely estimates based on the history of the companies. Also we submit preauthorizations for treatment when possible to get written estimates from insurance companies. These too are not guarantees of coverage since insurance companies in rare cases have refused to pay on written preauthorizations. We will make every effort to assist patients in working with their own insurance companies should claims be denied. It is the patient and not the dental office that has the contract with the Dental Insurance company for coverage and we are not responsible for errors in estimates, eligibility, or preauthorization.

______________________________ ____________

Insured Date

I the above assigned understand that I am responsible for all fees not covered by my insurance plan and that any quotes, preauthorizations, or eligibility information provided to me by Almaden Dental Associates is extended as a courtesy and for accuracy should be confirmed by me with my insurance company.

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