Joyful Smile Family Dentistry
Jeuel "Joy" D. Española, D.M.D.

New Patient Information

Name: _____ Date: _____

What name would you like to be called?: _____ Date of Birth:_____

Home Phone: _____ Social Security No: _____

Cell Phone: _____ E-mail: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____

Work Address: _____ City: _____ State: ____ Zip: _____

School Name (if full time student): _____

Marital Status: Married ○ Divorced ○ Single ○ Widowed ○

How would you like to confirm your appointments? Phone Call ○ E-mail ○

Whom may we thank for referring you to our office?: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name: _____ Phone #: _____

Insured's Name: _____ Relation to Patient: _____

Insured's Date of Birth: _____ SSN: _____ Member ID: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name: _____ Phone #: _____

Insured's Name: _____ Relation to Patient: _____

Insured's Date of Birth: _____ SSN: _____ Member ID: _____

Person Responsible For Account

Name: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ E-mail: _____ SSN: _____

Emergency Information – Person to contact in case of emergency

Name: _____ Relation to Patient: _____

Phone Number: _____ Secondary Phone Number: _____

E-mail: _____

Medical History

Your current physical health is: Good ◯ Fair ◯ Poor ◯

Are you currently under the care of a physician? Yes ◯ No ◯

Physician Name: _____

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? Yes ◯ No ◯

If yes, please list:

_____

Do you use or smoke tobacco in any form? Yes ◯ No ◯

Have you or do you take Redux/Fen Phen or Pondimin? Yes ◯ No ◯

For Women:

Are you taking birth control pills? Yes ◯ No ◯

Are you pregnant? Yes ◯ No ◯ Week # ____ Are you nursing? Yes ◯ No ◯

Have you ever had any of the following diseases or medical problems?

Angina Pectoris	YES ☐	NO ☐	Heart Attack	YES ☐	NO ☐	Thyroid Problems	YES ☐	NO ☐
Abnormal Bleeding	YES ☐	NO ☐	Heart Murmur/Mitral Valve Prolapse	YES ☐	NO ☐	Tuberculosis	YES ☐	NO ☐
Alcohol/Drug Abuse	YES ☐	NO ☐	Heart Disease	YES ☐	NO ☐	Ulcers	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	Heart Surgery	YES ☐	NO ☐	Venereal Disease	YES ☐	NO ☐
Alzheimer's Disease	YES ☐	NO ☐	Hemophilia	YES ☐	NO ☐	Anti-Cancer Drugs	YES ☐	NO ☐
Arthritis/Gout	YES ☐	NO ☐	Hepatitis	YES ☐	NO ☐	Cortisone Medicine	YES ☐	NO ☐
Artificial Bones/Joints/Valves	YES ☐	NO ☐	Herpes/Fever Blisters	YES ☐	NO ☐	Frequent Headaches	YES ☐	NO ☐
Asthma	YES ☐	NO ☐	Shingles	YES ☐	NO ☐	Glaucoma	YES ☐	NO ☐
Blood Transfusions	YES ☐	NO ☐	HIV+/AIDS	YES ☐	NO ☐	Hay Fever	YES ☐	NO ☐
Blood Disease	YES ☐	NO ☐	Kidney Problems	YES ☐	NO ☐	Sickle Cell Disease	YES ☐	NO ☐
Cancer/Chemotherapy	YES ☐	NO ☐	Liver Disease	YES ☐	NO ☐	Sinus Problems	YES ☐	NO ☐
High/Low Blood Pressure	YES ☐	NO ☐	Lung Disease	YES ☐	NO ☐	Stroke	YES ☐	NO ☐
Colitis	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐	Epilepsy/Seizures	YES ☐	NO ☐
Congenital Heart Defect	YES ☐	NO ☐	Nervous/Anxious	YES ☐	NO ☐	Fainting Spells	YES ☐	NO ☐
Difficulty Breathing	YES ☐	NO ☐	Pacemaker	YES ☐	NO ☐	Reumatic/Scarlet Fever	YES ☐	NO ☐
Emphysema	YES ☐	NO ☐	Radiation Treatment	YES ☐	NO ☐	High Cholesterol	YES ☐	NO ☐

Are you allergic to any of the following items?

Asprin	YES ☐	NO ☐	Latex	YES ☐	NO ☐	OTHER (if yes, see below)	YES ☐	NO ☐
Codeine	YES ☐	NO ☐	Penicillin	YES ☐	NO ☐			
Dental Anesthetics	YES ☐	NO ☐	Tetracycline	YES ☐	NO ☐			

*Please list any other drugs that you are allergic to:*_____

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Dental History

Name: _____ **Date:** _____

Reason for today's visit: _____

Previous Dentist: _____ **Phone #:** _____

Date of last dental visit: _____ **Date of last teeth cleaning:** _____

Date of last full mouth x-rays: _____

Our goal is to make your experience in our office exactly how you want it to be. Please complete the following so we can make you as comfortable as possible!

What concerns you most about your mouth? _____

Are any of your teeth sensitive to:

Hot?	YES ☐	NO ☐	**Where?** _____
Cold?	YES ☐	NO ☐	**Where?** _____
Sweets?	YES ☐	NO ☐	**Where?** _____
Biting or chewing?	YES ☐	NO ☐	**Where?** _____

Are you concerned about:

Replacing or missing teeth? ---------- YES ☐ NO ☐

Eliminating any disease present in your mouth? ---------- YES ☐ NO ☐

Gum Disease? ---------- YES ☐ NO ☐

Bad Breath? ---------- YES ☐ NO ☐

The appearance of your smile? ---------- YES ☐ NO ☐

Jaw Pain (TMJ) ---------- YES ☐ NO ☐

Are your teeth wearing down? ---------- YES ☐ NO ☐

Is keeping your teeth natural important to you? ---------- YES ☐ NO ☐

Patient HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Dr. Jeuel Española

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Patient Name (Print) Relation to Patient (If Minor)

_____ _____

Signature Date

Patient Medical Consent Form

I understand that this information is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I authorize the sharing of records to specialists for completion of my treatment. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes. I authorize my active insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance

_____ _____

Signature Date

Estimated patient portion is due in full at the time of treatment. If for any reason, your insurance company has not made payment within 30 days you are responsible for payment in full at that time.

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Cancellation Policy

As a dental practice, we understand that **time is valuable**. Upon scheduling your appointment, we dedicate our time for you to be seen in our office.

In order to be respectful of the dental needs of other patients, we require that you notify our office a **minimum of 2 business days** before your scheduled appointment if you need to cancel or make any changes to your appointment. This enables us to accommodate other patients in need of an appointment in a timely manner.

Missed appointments not only create an inconvenience to us and other patients, but also put a financial burden on our practice when we keep staff and other resources available for appointments that are not kept.

As a result, a **missed appointment fee of $100** will be charged to your account for each appointment that is missed without proper notice. However, exceptions of this policy will be considered on a case by case basis.

This is the only correspondence we will give/send you regarding missed appointments. Please give us a call at (510) 713-2245 if there are any questions regarding this policy.

Sincerely,

Joyful Smile Family Dentistry

By signing this letter I have acknowledged that Joyful Smile Family Dentistry requires 2 business days notice of any cancellations or changes to my appointment.

_____ _____

Patient's Name (Print) Patient's Signature

_____

Date