SHAUN BURLINGAME, DDS, MD

Confidential Registration and Medical History

PATIENT INFORMATION

Patient Name:______________________________ Preferred Name:_____________________ Sex: ____M ____F

Date of Birth:__________________SSN: __________________________ Home Phone:__________________________

Cell Phone:___________________ Work Phone:___________________ Name of Employer:_________________________

Mailing Address:____ Zip Code: ________________________

☐Please check box if you prefer contact by Email:____

Name of Dentist: ____________________________Primary Care Physician:_______________________________________

Pharmacy: ____

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Responsible Party Name:_____________________________________Relationship to Patient:________________________

Address:____ Zip Code:_________________________

Phone:_____________________________ Date of Birth:___________________________ SS#:________________________

INSURANCE INFORMATION

Dental Insurance Company:_____________________________ Policyholder's Name:_______________________________

Relationship to Patient:_____________________ SS#:_____________________ Date of Birth:_____________________

Member ID:____ Group No.:____

Name of Employer:___________________________________ Employer Phone:____________________________________

Secondary Insurance Company:_________________________ Policyholder's Name:_______________________________

Relationship to Patient: ___________________ SS#:______________________ Date of Birth:_______________________

Member ID:____ Group No.:____

Name of Employer: ___________________________________ Employer Phone: _________________________________

Assignment and Release: I understand that I am financially responsible for all charges, whether or not paid by insurance. I, the undersigned, have insurance with _________________________ and assign directly to Shaun Burlingame, DDS, MD, all benefits, if any, otherwise payable to me for services rendered. I hereby authorize Shaun Burlingame, D.D.S, M.D., 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.

Date: ______________________________________ Signature: ____

CONFIDENTIAL HEALTH HISTORY

Please answer all questions by circling YES (Y) or NO (N)

1. Are you in good health? Y N
2. Have you had any serious illnesses, operations or hospitalizations? Y N
   If so, please describe: ________________________________
   ____
   Height: _________________ Weight: ______________
3. **Do you have, or have you <u>ever</u> had (please <u>indicate which conditions</u> apply to you):**
   a. Rheumatic Fever or Rheumatic Heart Disease Y N
   b. Congenital Heart Disease Y N
   c. Cardiovascular Disease (heart trouble, heart attack, murmur, coronary artery disease, angina, stroke, palpitations, heart surgery or pacemaker placement)? Y N
   d. High Blood Pressure Y N
   e. Breathing Difficulty (asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorder)? Y N
   f. Snoring or Sleep Apnea Y N
   g. Fainting, dizziness, nervous disorders, seizures or epilepsy? Y N
   h. Bleeding Disorder (anemia, bleeding tendency, blood transfusion, bruise easily)? Y N
   i. Liver or Kidney Disease (Hepatitis, Jaundice)? Y N
   j. Herpes or MRSA skin infection? Y N
   k. Diabetes? Y N
   l. Arthritis? Y N
   m. Thyroid Disease (goiter)? Y N
   n. Stomach Ulcers or Colitis? Y N
   o. Glaucoma? Y N
   p. Mouth Sores (frequent or recurring)? Y N
   q. Implants placed in your body (knee, hip, etc.)? Y N
   r. Radiation treatment for cancer? Y N
   s. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth? Y N
   t. Sinus or nasal problems? Y N
   u. Any disease, drug or operation that has depressed your immune system? Y N
4. **Are you using any of the following?**
   a. Antibiotics? Y N
   b. Anticoagulants (blood thinners)? Y N
      Please list: __________________________________
   c. Aspirin, or drugs such as Aleve or Ibuprofen? Y N
   d. Blood Pressure medication? Y N
   e. Steroids (Cortisone, Prednisone, etc.)? Y N
   f. Tranquilizers (Valium, etc.)? Y N
   g. Insulin or other Diabetic medications? Y N
   h. Digitalis, Inderal, Nitroglycerin, or other heart medications? Y N
   i. Are you taking, or have you ever taken bisphosphonates (Fosamax, Actonel, Boniva for osteoporosis, or Zometa or Aredia for chemotherapy, etc.)? Y N
   j. Are you taking, or have you ever taken weight loss drugs (Phen-Fen, etc.)? Y N
   k. <u>PLEASE LIST ALL MEDICATIONS TAKEN:</u>
      ____
      ____
   l. Are you a Pre-Med? Do You take an antibiotic before any dental procedures? Y N
5. **Are you <u>ALLERGIC</u> to, or had an adverse reaction to:**
   a. Latex or rubber products? Y N
   b. Local Anesthetic (Novocain, etc.) Y N
   c. Penicillin or other antibiotics? Y N
      Please list: ______________________________
   d. Aspirin or Ibuprofen Y N
   e. Codeine or other pain killers? Y N
   f. Other allergies or reactions? Please list:
      ____
6. Do you currently or have you ever smoked or chewed tobacco? Y N
7. Do you currently use or have a history of using recreational drugs? Y N
8. Is there a past history of chemical dependency? Y N
9. Have you or an <u>immediate</u> family member had any problems associated with intravenous sedation? Y N
10. Do you have any other disease, condition or problem not listed that you think the doctor should be aware of? Y N
11. Do you wish to talk to the doctor privately? Y N
12. **For women only**:
    a. Are you pregnant, or is there any chance you might be pregnant? Y N
    b. Are you nursing? Y N

I understand the importance of a <u>truthful</u> Health History to Dr. Burlingame in providing the best care possible and I will not hold my care providers responsible for any errors or omissions that I may have made. I certify that I have read and understand the above.

Date: _________________ Signature: ______________________________________

Shaun Burlingame, D.D.S., M.D.
316 Knollcrest Drive | Redding, CA
P 530.223.1811 | F 530.223.1813

OUR FINANCIAL POLICY

It is very important that you read this document carefully!

If you are covered by dental insurance, we will collect your **estimated** co-payment, any deductible not yet met, and 100% of any procedure not covered by your dental insurance policy. This will be due at the time services are rendered. This amount is an estimate based on the quoted benefits given by your insurance company and is subject to the final review of your insurance company. After 60 days, if your claim has not been paid by your insurance company, the balance due is your responsibility.

We are not a provider for Medicare, or any other medical insurance. Medicare will not pay for any procedure that is performed by Dr. Burlingame, and the cost is due in full by you, the patient, at the time services are rendered.

If you are a cash paying patient, payment is due on the day of your treatment surgery. There are no exceptions.

For extensive surgeries, such as full mouth extractions or facial trauma surgery, 50% of the cost of your procedure is due at the time of your consultation if you elect to schedule the procedure with our office. The remaining 50% is due on the day of surgery. There are **no** exceptions.

We do not offer a payment plan. You may inquire about Care Credit if you would like to establish a dental/medical line of credit to pay for your visit. This must be arranged **prior** to your treatment time. Past due accounts are sent immediately to collections.

We ask that you sign below as an acknowledgment that you have read and understand our financial policy. This policy is effective December 1, 2009.

By signing, I acknowledge that I have read the above Financial Policy and agree to the terms as stated above.

____ Signature of Patient or Legal Guardian

______________________ Date

Notice of Privacy Practices Patient Acknowledgement

Patient Name:

Date of Birth:

I have recognized this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature:

Date:

Relationship to patient:

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