JAMES BLOCK DENTISTRY

We are honored that you have chosen James Block Dentistry as your dental provider. We are constantly staying up on the leading technology and re-investing in our practice so we can deliver top notch, gentle, compassionate care. As our patient, he and his staff will diagnose and treat with the fullest intent of the absolute best and gentle care possible.

_____X-Rays

Our office is equipped with the latest, state of the art, safe technology in digital dental radiographs. We will need any current x-rays including *Panorex* (that are less than 5 years old) and *Bitewings* (less than 1-year-old). It is the patient's responsibility to make sure we have any current x-rays in time for your first appointment. Please be sure to call your previous dental care provider or other providers that may have any x-rays and have them sent to us. Our email is dentalblock@yahoo.com. Current x-rays are vital for Dr. Block to do a complete comprehensive exam in order to provide top quality care. ***If we do not have current x-rays in time for your appointment, we will take them in our office in order to have a complete exam. If your insurance does not pay for them, you will be responsible for the cost.***

_____Medicine

If you need to pre-medicate prior to your appointment for any reason, or if you are on any type of blood thinner, please let us know in advance of your appointment. We can kindly remind you to take your pre-medication prior to your scheduled appointment time if we need to. However, it is ***your*** responsibility to make sure you have pre-medicated. If you arrive for your appointment and have not pre-medicated, and the doctor is unable to complete your appointment, you may be charged an office visit. It is very important that Dr. Block knows all medicines that you are taking, please list all of them.

_____Appointments

Your scheduled appointment time has been reserved specifically for you. We require 48-hour notice if you need to cancel your appointment. If you fail to make your appointment or do not give us a 48-hour cancellation notice(over voicemail is not accepted), you will be charged $75 for the appointment. We also reserve the right to take a deposit of $250 for procedures costing over $1,000. We are aware that unforeseen events sometimes require missing an appointment. Recurrent broken or failed appointments may result in dismissing services as your provider.

_____Insurance

It is the patient's responsibility to know and understand your plans benefits. We will file your insurance as a courtesy but expect your estimated portion to be paid on the date of service. Because insurance policies vary we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. If you need to know exactly what is covered and what is not, you will need to call your insurance company. We are a provider for many plans but will file all insurance claims at the courtesy of you, our patient. At no time will we diagnose or treat our patients limiting ourselves under the guidelines of your insurance coverage.

_____Payment

Your estimated patient portion must be paid at the time of service. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If special financial arrangements are needed, an extended payment plan is available through Care Credit. Dr. Block's office offers no interest plans through Care Credit up to 12 months. More information about this plan is available at www.carecredit.com.

Please initial each guideline of James Block Dentistry, sign and date this page. Again, thank you for allowing us to take care of your dental needs.

{Sign}_____ {Date}_____

James F. Block, D.D.S.
1895 Mowry Ave., Suite 114
Fremont, CA 94538
(510) 510-793-0801

PATIENT INFORMATION

Date_____ SS#_____--_____--_____ Birth Date_____

Name_____ Home Phone_____
Last First M.I.

Address_____ Cell Phone_____

City_____ State_____ Zip_____ E-mail_____

Sex: Male Female (Circle one) Status: Minor Single Married Long-term Partner Divorce Separated Widowed (Circle one)

Employer_____ Bus. Phone_____

Bus. Address_____

Occupation_____ Phone_____

Referred By_____

PRIMARY DENTAL INSURANCE

Person responsible for account _____
Last First M.I.

Relationship to patient _____Birth Date _____ SS#_____-_____-_____

Address_____Home Phone_____

City_____ State_____ Zip_____

Responsible party employed by_____ Bus. Phone_____

Bus. Address_____ Occupation_____

Insurance Co._____ Ins. Co. Phone _____
_

Ins. Co. address_____

Subscriber ID#_____Group#_____

ADDITIONAL DENTAL INSURANCE

Insured Name_____
Last First M.I.

Relationship to patient _____ Birth date_____ SS#_____--_____--_____

Address_____ Home Phone _____

City_____ State_____ Zip_____

Insured employed by_____ Bus. Phone_____

Insurance Co._____ Ins. Co. Phone _____

Ins. Co. Address_____

Subscriber ID#_____ Group#_____

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
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 Sexual transmitted disease
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	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	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	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

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, what month? _____

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 ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition 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