Lance Metsger, DMD & Viren R. Patel, DDS

6610 Folsom-Auburn Road, Suite 8, Folsom, Ca 95630 (916) 988-3402

Patient Information

Date _____
Patients Name_____ Preferred Name_____ Male/Female_____
Home Address_____ City _____ State _____ Zip_____
Age _____ Birth Date _____ Social Security # _____Cell #_____
E-mail address_____ Additional Contact # _____

If patient is a minor, give parent's or guardian's name _____
How did you hear about our office? _____
Has any member of your family been at this office before? Names: _____

Medical History

Does the patient have or has he/she ever had any of the following conditions:

Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Hepatitis/Liver Disease
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Disease	☐	☐	Epilepsy
☐	☐	Lung Disease	☐	☐	Scarlet Fever
☐	☐	Thyroid Disease	☐	☐	Nervous Disorder
☐	☐	High Blood Pressure	☐	☐	AIDS / HIV +
☐	☐	Metallic Implant	☐	☐	Tuberculosis
☐	☐	Glaucoma	☐	☐	Cold Sores/ Fever Blister
☐	☐	Blood Transfusion	☐	☐	Bleeding Gums
☐	☐	Women: Are you Pregnant Now?	☐	☐	Injury to Front Teeth
☐	☐	Tumor/Cancer	☐	☐	Bad Breath
☐	☐	Prolonged Bleeding When Cut	☐	☐	Stained tooth
☐	☐	Have you taken Osteoporosis Meds?	☐	☐	Latex or Metal Allergy
☐	☐	Have you taken Fen Phen, Redux or similar? ☐	☐		Tobacco/ Marijuana

Please list any food or drug allergies. _____
Please list all current medications. _____
_____
Please list any vitamins or herbal supplements regularly taken. _____
_____
Has the patient recently been under the care of a physician? If yes, for what reason?_____
_____
Name of medical doctor for above reason _____
Has the patient been hospitalized in the past five years? If yes, please explain. _____
_____
Has the patient had a serious illness or operation? If yes, please explain. _____
_____
Does the patient suffer from headaches? If yes, how often and how severe? _____
_____

Important Note: I will immediately inform the doctor if there are any changes in the medical history.

Patient/Guardian Signature _____Date_____Reviewed_____Date_____

Dental History

Last Dental Care: Date _____
Dentists Name_____ Address _____
Nature of Dental Care Provided _____

Responsible Party Information

Name _____ Birth Date _____ Social Security # _____
Address _____Phone _____
Employer _____ Occupation _____
Employer's Address _____ Work Phone _____

Spouse's Name _____ Birth Date _____Social Security # _____
Spouse's Address (if different) _____Phone _____
Spouse's Employer _____ Occupation _____
Employer's Address _____ Work Phone _____

Dental Insurance Information

Insured's Name_____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Phone # _____
Insurance Co. Address _____

Do you have dual Coverage? ☐ Yes ☐ No If yes:
Insured's Name_____ Insured's Soc. Sec. # _____
Insurance Company _____Group # _____ Phone # _____
Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you. _____ Phone _____

Complete Address _____

I give my consent for Dr. Patel to do a complete/emergency oral and dental examination on the patient named previously. X-rays that are necessary to properly complete the exam may be taken. If a cleaning, fluoride treatment, and oral hygiene instruction are to be included in the first examination, I will be informed. Any additional dental treatment received will be fully explained prior to starting treatment.

I understand that I am fully responsible for the cost of any treatment carried out regardless of insurance.

Additional Comments: _____
_____
_____
_____
_____
_____

I have also received a copy of the Dental Materials Fact Sheet.

Signed _____Date_____

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Regarding Insurance

For your convenience, we will process your dental claims with your insurance company. In return, we ask that you pay your deductibles and co-pays on the day treatment is rendered. Most insurances will not cover 100% of our fees. We will estimate the portion not covered by your insurance. Our estimates may differ from your insurance company's actual payment; therefore the amount due our office will be adjusted accordingly**. The balance is your responsibility whether your insurance company pays or not.** If your dental insurance does not pay their portion **within 45 days** of your treatment, you are responsible for full payment of the balance at that time. It is also your responsibility to inform us of changes in your insurance coverage.

Payment Options

1. We offer a 5% discount for your treatment if payment is made for the entire plan.
2. We accept cash, checks, and most credit cards
3. We offer outside financing through Care Credit.
4. We offer a 10% Senior Discount to patients 62 years or older who pay in full before treatment begins

Missed Appointments

Please help us serve better by keeping scheduled appointments. Missed or cancelled at the last minute appointments are unavailable to patients anxiously awaiting dental care. If the need to cancel a scheduled appointment arises, we request **48** hours notification. Appointments cancelled with less than 48 hours notice are subject to a **$50 fee**. Therefore, please consider your schedule carefully when making appointments.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have any questions.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Signature/Responsible Party _____Date_____

Financial Arrangement

Patient Name: _____

Treatment Plan:

Total Estimated Fee:	$_____
Estimated Insurance Coverage:	$_____
Prepayment Savings:	$_____
Estimated Patient Portion:	**$_____**

_____	_____	_____
Date	Patient/Responsible Party	Team Member