Welcome to Our Practice!

Will you please help us by providing us with the

Following confidential information?

William M. Netzley D.D.S.
5151 N. Palm Ave, Suite 450
Fresno, CA 93704
(559) 227-4078

PATIENT INFORMATION:

Whom may we thank for referring you? _____

First Name:_____ M.I. ___ Preferred Name _____ Last Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Mailing Address: _____

City, State, Zip-_____ Date of Birth:_____ Age: _____

SS#: _____ Driver's License _____ Sex: M or F Occupation: _____

- o Single Employer: _____ Address, City, State, Zip:_____
- o Married
- o Divorced Emergency Contact Name:_____Phone _____
- o Widowed
- o Separated Spouse's Name: _____Occupation: _____

Spouse's Address (if different than above): _____ City, State, and Zip: _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Company: _____ Address: _____

City- _____ State:_____ Zip: _____ Phone: _____

Policy Holder Name: _____ SS#:_____ Birth Date:_____

Insured's Employer:_____ Group # or Policy #: _____

Relation: _____

Secondary Insurance Company: _____ Address:_____

City:_____ State: Phone: _____

Policy Holder Name: _____ SS#: _____ Birthdate:_____

Group # or Policy #: _____ Insured's Employer_____

Relation: _____

MEDICAL HEALTH HISTORY

A. CIRCLE YOUR ANSWERS

1. Yes No Are you in good health?

2. Yes No Has there been a change in your health within the last year? Explain:_____

3. Yes No Have you Been hospitalized or had a serious illness in the last 5 years? Explain:_____

4. Yes No Are being you being treated by a physician now? For what? _____

Name of your physician: _____

Physician Phone # : _____ Date of last medical Exam: _____

B. ARE YOU CURRENTLY EXPERIENCING:

5	Yes No	Chest Pains	17.	Yes No	Ringing in ears
6	Yes No	Swollen Ankles	18.	Yes No	Sleep apnea or chronic snoring
7	Yes No	Shortness of breath	19.	Yes No	Dry Mouth
8	Yes No	Recent weight loss, fever, night sweats	20.	Yes No	Frequent headaches
9	Yes No	Persistent cough, coughing up blood	21.	Yes No	Fainting spells
10	Yes No	Bleeding problems, bruising easily	22.	Yes No	Blurred vision
11	Yes No	Sinus problems	23.	Yes No	Seizures
12	Yes No	Difficulty swallowing	24.	Yes No	Excessive thirst
13	Yes No	Diarrhea, constipation, blood in stools	25.	Yes No	Frequent urination
14	Yes No	Frequent vomiting, nausea	26.	Yes No	Jaundice
15	Yes No	Difficulty urinating, blood in urine	27.	Yes No	Joint pain, stiffness
16	Yes No	Dizziness	28.	Yes No	Migraines

C. **DO YOU HAVE OR HAVE YOU HAD:**

29.	Yes No	Heart disease	41.	Yes No	Drug abuse/addiction
30.	Yes No	Heart attack, heart defects	42.	Yes No	Tumors, cancer
31.	Yes No	Heart Murmurs	43.	Yes No	Arthritis, rheumatism
32.	Yes No	Rheumatic fever	44.	Yes No	Eye disease
33.	Yes No	Stroke, hardening of arteries	45.	Yes No	Skin disease
34.	Yes No	High blood pressure	46.	Yes No	Anemia
35.	Yes No	TB, emphysema or other lung diseases	47.	Yes No	VD (syphilis or gonorrhea)
36.	Yes No	Hepatitis **A B C D E**	48.	Yes No	Herpes
37.	Yes No	Stomach problems	49.	Yes No	Kidney, bladder disease
38.	Yes No	Diabetes	50.	Yes No	Thyroid, adrenal diseases
39.	Yes No	Family History of diabetes, heart problems, cancer	51.	Yes No	Osteoporosis
40.	Yes No	HIV positive or AIDS-ARC	52.	Yes No	Latex allergy

D. DO YOU HAVE OR HAVE YOU HAD:

53.	Yes No	Surgeries	Date:_____
54.	Yes No	Blood transfusion	Date:_____
55.	Yes No	Artificial Joint	Date:_____
56.	Yes No	Contact lenses	Date:_____
57.	Yes No	Psychiatric care	Date:_____
58.	Yes No	Radiation treatment	Date:_____
59.	Yes No	Chemotherapy	Date;_____
60.	Yes No	Prosthetic heart valve	Date:_____
61.	Yes No	Pacemaker	Date:_____
62.	Yes No	Birth Control Pills	Date:_____
63.	Yes No	Pregnant or nursing	Date:_____

E. DO YOU TAKE OR HAVE YOU TAKEN:

64.	Yes No	Recreational drugs	70.	Yes No	Alcohol
65.	Yes No	Tobacco in any form	71.	Yes No	Antacids
66.	Yes No	Fen-Phen, Pondimen;Redux			
67.	Yes No	Take any herbal supplements			
68.	Yes No	Bisphosphonates			
69.	Yes No	Regularly drink grapefruit juice			

ALLERGIES: Drugs, food, medications, metal, jewelry, acrylics

_____

_____

_____

LIST ALL MEDICATIONS THAT YOU TAKE: ⬇

_____

_____

_____

_____

_____

F. All Patients:

72. Yes No Do you have or have you had any other diseases of medical problems NOT listed on this form? If so, explain:

_____

73. Yes No Have you ever been told by a physician or a dentist that you need to be pre-medicated or given antibiotics prior to any dental Treatment? If so, explain: _____

PATIENTS ADDITIONAL COMMENTS: _____

_____

DENTAL HEALTH HISTORY:

74. Name of previous dentist: _____ how long since you were last seen? _____

75. Is keeping your teeth important to you? Yes No If yes, why? _____

76. On a scale of 1-10, 10 being the best, where would you rate your smile? _____

77. On a scale of 1-10, 10 being the best, where would you rate your oral health? _____

78. Are you currently experiencing any of the following problems:

Bleeding gums [Y] [N]	Sensitivity to hot & cold [Y] [N]
Bad breath or sour taste in mouth [Y] [N]	Snoring [Y] [N]
Burning sensation in mouth [Y] [N]	Food catching between teeth [Y] [N]
Soreness in jaw [Y] [N]	Grinding of teeth [Y] [N]
Is it hard for you to open wide [Y] [N]	Pain/soreness around ears, eyes, face [Y] [N]
Clicking or popping in jaw [Y] [N]	Stiff neck muscles [Y] [N]
Had your parents suffered from Gum disease [Y] [N]	Did your parents wear dentures/partials [Y] [N]
Did you ever wear braces [Y] [N]	Ever been injured in your mouth or head [Y] [N]
Have you had any oral surgery of any kind [Y] [N]	Do you smoke or chew tobacco [Y] [N]

79. Does having dental treatment make you afraid or nervous? [Y] [N] If yes, what specific things bother you? _____

_____

80. Is the brightness of your teeth important to you? [Y] [N]

81. If you could change anything about your smile, which of the following would you want?

Whiter [Y] [N]	Close space or spaces [Y] [N]	Replace chipped teeth [Y] [N]
Replace missing teeth [Y] [N]	Replace old crowns [Y] [N]	Remove silver fillings [Y] [N]
Remove stains / Spots on teeth [Y] [N]	Excess showing of teeth [Y] [N]	Replace old plastic filling(s) [Y] [N]
Straighter [Y] [N]	Less gum showing [Y] [N]	Reshape/ resize my teeth [Y] [N]

82. Fill in this question for us please: Where do you see yourself and your overall oral health and/or smile in the next 5 to 10 years?

_____

_____

Please circle the following which are important to you when making you dental health decision:

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or anxiety	Comfort	Technology

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest 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

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of William M. Netzley, D.D.S. Notice of Privacy Practices dated February 19, 2020
*Others authorized to request information on my behalf:

Patient Signature _____ Date _____

FINANCIAL ARRANGEMENT AGREEMENT

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that Payment at the time of your treatment is considered a part of your commitment to our office. Payment is required at the time of treatment. Should you have any insurance benefits that we will be filing for you, your co-pay and deductible are due in full at the time of treatment. We accept cash, check, debit cards as well as Visa, MasterCard, American Express, and Discover credit cards. We offer extended payment plans options through Care Credit, at either little or NO interest with prior credit approval.

REGARDING INSURANCE

We will gladly file all dental claims for the given treatment but we are not party to any insurance programs or contracts. We are a nonrestrictive provider. The balance if YOUR responsibility, whether your insurance carrier pays for your treatment or not. It is YOUR responsibility after 30 days of sending our payment form to your insurance carrier, the TOTAL balance due on the account will be owed.

DENVANTAGE MEMBERSHIP PLAN

We offer an exclusive in office monthly membership plan to patients without insurance. No maximum limitations or annual deductibles. You pay a monthly fee and receive preventative care for the entire year as well as special discounted prices on treatment you may need.

MISSED APPOINTMENTS

In order to be fair to all of our patients, we ask that you notify our office, at least 48 hours in advance should you have a conflict with your scheduled appointment. Failure to contact the office or doctor may result with a charge of an office visit.

FINANCE CHARGES

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 27%. I further understand that this finance charge is equal to 3.25% of my outstanding balance per month. I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If, Dr. Netzley, D.D.S., must take additional steps to collect my account, I will pay all cost of the collection, including court cost and attorney's fees incurred by Data Central.

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have questions. Our financial coordinator would be glad to review the agreement with you at any time.

Patient Name (Print)_____

Patient Signature _____ Date _____

Co-signer or Guardian Name (Print) _____

Co-signer or Guardian Signature _____Date_____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA. THE CDC AND THE ADA.