



Legacy Dental

27701 Scott Road Suite 107 • Menifee, CA 92584 • 951.301.6100

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION

Name: LAST: _____ FIRST _____ M.I. _____ PREFERRED _____

Address: STREET _____

CITY _____ STATE _____ ZIP CODE _____

DOB: _____ Male Female Social Security #: _____

Email: _____ If applicable, Spouses/Parent Name: _____

Home (_____) _____ Work (_____) _____ Mobile (_____) _____

Single Married Widowed Divorced

Emergency Contact Name: _____ Phone: (_____) _____

How would you like to receive appointment reminders? (Please circle): Phone Call Email Text

Employer: _____ May we contact you at work? Yes No

How did you hear about us? _____

DENTAL INSURANCE

Primary Dental Carrier

Insurance Co: _____ Insurance Phone #: _____

Subscriber Name: _____ Social Security #: _____ DOB: _____

Employer: _____ Group #: _____ Relation to patient: _____

Secondary Dental Carrier

Insurance Co: _____ Insurance Phone #: _____

Subscriber Name: _____ Social Security #: _____ DOB: _____

Employer: _____ Group #: _____ Relation to patient: _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature: _____ Date: _____

If Patient is Under 18

Responsible Party: _____ Relation to Patient: _____

Address: STREET _____

CITY _____ STATE _____ ZIP CODE _____ Phone: _____



Legacy Dental

27701 Scott Road Suite 107 • Menifee, CA 92584 • 951.301.6100

DENTAL EVALUATION

Patient's Name: _____ Date: _____

Is there anything about your smile that you don't like? _____

Do you have any missing teeth? _____

Is your bite comfortable for chewing, biting? _____

Do you have any old fillings or dental work that you don't like? _____

Would you be interested in enhancing your smile with whiter, more aligned teeth? Yes No

If nervous, would you like to have your dentistry done with laughing gas (nitrous oxide)? Yes No

Is there anything about your mouth that concerns you now? Yes No

If yes, please explain: _____

When were you last seen at the Dentist? What treatment was done? _____

Were X-Rays taken at this last visit? Yes No

Have you ever had orthodontic treatment? Yes No

Do you use dental floss or toothpicks? Yes No

Have you ever had your wisdom teeth removed? Yes No

Do your gums ever bleed? Yes No

Are any of your teeth loose? Yes No

Do you have any swelling, sores or blisters in your mouth? Yes No

Have you ever been told that you have gum disease? Yes No

Have you ever visited a periodontist (gum specialist)? Yes No

Do you smoke? Yes No

Do you feel you have unpleasant breath at times? Yes No

Are you interested in using sedatives while dental treatment is being performed? Yes No

How would you describe your dental health on a scale of 1-10 with 10 being the best? _____

Is there anything else we should know about? Have you had any prior dental experiences that were not pleasant? Is there anything that we can do to make your dental visits more comfortable? _____



Legacy Dental

27701 Scott Road Suite 107 • Menifee, CA 92584 • 951.301.6100

OFFICE POLICY

NO SHOW AND CANCELLATION

In order to continue providing excellent quality, yet affordable dental services, it is important for our patients to understand that appointments are reserved for you in advance; please make every effort to keep your appointments. **You must notify us within at least 48 hours in advance if you need to reschedule or cancel your appointment. Failure to notify us 48 hours in advance will result in a \$45.00 charge to your account.**

ORAL SURGERY APPOINTMENTS

A \$250.00 deposit will be required to reserve an appointment for your surgery date. This fee will then be applied to dental work that is scheduled to be done.

PATIENTS WITH DENTAL INSURANCE

It is your responsibility to provide our office with your dental plan and to let us know of any changes at your appointment. We will continue to try and help you understand your policy but please be aware that there are thousands of different policies and we do not know all of the limitations for all the plans out there. If for any reason your insurance company does not pay for a procedure, the balance is your responsibility to pay in full upon receipt of the statement.

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCUR:

- The treatment goes over my yearly maximum.
- Any treatment that is denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay by not complying with requests for insurance forms or signatures.
- I do not complete my treatment and it results in non-payment by the insurance company.
- Lab and equipment costs that incurred due to a missed appointment.
- I received my insurance check and do not sent it to the office.

By signing this, I have read and understand the above policy.

Patient Signature

Date

If patient is under 18, Parent/Responsible Party's Signature

Date



Legacy Dental

27701 Scott Road Suite 107 • Menifee, CA 92584 • 951.301.6100

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations.

Patient Name: _____ DOB: _____

Patient Signature Date

If patient is under 18, Parent/Responsible Party's Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- Other (Please Specify): _____

Employee Name: _____

Employee Signature: _____