BLOOMVALEDENTAL

BloomvaleDental.com
5337 Hamner Ave Unit 707
Eastvale, CA 91752
951-325-4600

Patient Information:

Date:______________

Name:____ Prefer to be called:_______________________ ☐Male ☐Female

Address:_______________________________________ City:_________________________ State:______ Zip:_____________

Primary Phone:____________________________________ Secondary Phone:_______________________________________

Email:____

DOB:____________________ Driver's License:____________________ SSN:_______________________________

Contact preference: ☐ Call ☐ Text ☐ E-mail

Marital Status: ☐Married ☐Single ☐Divorced ☐Other ☐Minor

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? ____

Phone:____________________ Relationship to patient:____

Person financially responsible for this account? ____

Relationship:____

Who may we thank for referring you to our office? ____

For Insurance Purposes:

Primary Dental Insurance

Employee_____________________________________

Employer_____________________________________

Insurance Co.__________________ Group#____________

Employee SS#__________________________________

Secondary Dental Insurance

Employee_____________________________________

Employer_____________________________________

Insurance Co.__________________ Group#____________

Employee SS#__________________________________

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Dental History:

Reason for today's visit?____ Last dental visit Date_____________________

Have you ever had any serious problems with previous dental treatment?____

Do you feel discomfort in any of your teeth? ____

Do your teeth bleed when you brush or floss?____

Do you grind your teeth? Do you have joint/jaw pain? ____

Please rate your smile: 1 2 3 4 5 6 7 8 9 10 (best)   Please rate the color of your teeth: 1 2 3 4 5 6 7 8 9 10 (best)

Any other questions/concerns that have not been covered above?____

Here at Bloomvale Dental we offer a variety of services to enhance your comfort, and keep your smile beautiful. Please check any services below you would like our friendly staff to discuss with you during your visit.

☐ In Office Whitening	☐ Traditional Braces	☐ Clear Aligners
☐ Smile Design	☐ Veneers	☐ Extended Payment Plans
☐ Sealants	☐ Implants	☐ Partials/Dentures
☐ Take Home Whitening Trays	☐ Sedation	☐ Nighttime/Snore Appliances

Assignment and Release:

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between Dr. Chang or his Associates and myself. I also give permission for Dr. Chang or his Associates to use any photos they may take to be used for lecturing or education purposes.

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bloomvale Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Chang to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature:____ **Date:**___________________

Relationship:___________________________________