

B. Scott Hood, D.D.S., M.S., Inc.

WELCOME

Chico Office:
2755 Esplanade
Chico, CA 95973
Phone: (530) 343-7021

Paradise Office:
5657 Clark Road #5
Paradise, CA 95969
Phone: (530) 877-4951

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.

1

ABOUT YOU

Name _____
Preferred Name _____ Male Female
 Single Married Divorced Widowed Separated
Birthdate ____ / ____ / ____ Age ____ SS# ____ - ____ - ____
Address _____
City _____ State _____ Zip _____
E-mail _____
Home # _____ Work # _____
Cell # _____ DL # _____
General Dentist: _____
Last visit date _____
Other family members seen by us? _____
Employer _____
Employer Address _____

2

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Home # _____ Work # _____
Cell # _____ Birthdate ____ / ____ / ____
E-mail _____
Billing Address _____
City _____ State _____ Zip _____

3

SPOUSE INFO

Name _____
Home # _____ Work # _____
Cell # _____ Birthdate ____ / ____ / ____
E-mail _____

4

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No
Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birth Date _____ SS # _____
Policy Owner's Employer _____

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? Yes No
Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone # _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birth Date _____ SS # _____
Policy Owner's Employer _____

5a

MEDICAL HISTORY

Do you have a personal physician? Yes No
Physician's Name _____
Phone # _____ Last visit date _____
Are you currently under the care of a physician? Yes No
Please explain _____

IN THE EVENT OF AN EMERGENCY WHO SHOULD WE CONTACT?

Name _____ Relation _____
Home # _____ Work # _____

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5b

MEDICAL HISTORY

Your current physical condition Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Are you taking any prescription/over-the-counter or herbal supplement drugs? Yes No

Please list each one _____

Do you take or have taken medication for osteoporosis or metastatic bone cancer? Yes No

FOR WOMEN ONLY

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week # _____

Are you nursing? Yes No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASE OR MEDICAL PROBLEMS?

Yes	No	Abnormal Bleeding	Yes	No	Herpes / Fever Blisters
Yes	No	Alcohol / Drug Abuse	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	HIV + / AIDS
Yes	No	Artificial Bones, Joints, Valves, or Implants	Yes	No	Hospitalized for any reason
Yes	No	Asthma	Yes	No	Kidney Problems
Yes	No	Cancer / Chemotherapy	Yes	No	Liver Disease
Yes	No	Congenital Heart Defect	Yes	No	Lupus
Yes	No	Diabetes	Yes	No	Mitral Valve Prolapse
Yes	No	Difficulty Breathing	Yes	No	Pacemaker
Yes	No	Emphysema	Yes	No	Psychiatric Problems
Yes	No	Epilepsy	Yes	No	Radiation Treatment
Yes	No	Fainting Spells	Yes	No	Rheumatic / Scarlet Fever
Yes	No	Frequent Headaches	Yes	No	Seizures
Yes	No	Glaucoma	Yes	No	Sinus Problems
Yes	No	Heart Attack	Yes	No	Stroke
Yes	No	Heart Murmur	Yes	No	Thyroid Problems
Yes	No	Heart Surgery	Yes	No	Tuberculosis (TB)
Yes	No	Hemophilia	Yes	No	Ulcers
Yes	No	Hepatitis	Yes	No	

Please list other medical condition(s) that you have ever had _____

PLEASE LIST ALL DRUGS / MATERIALS THAT YOU ARE ALLERGIC TO:

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DENTAL HISTORY

Has your doctor told you that you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

No

Your current dental health is: Good Fair Poor

Do your gums ever bleed? Yes No

No

Do you like your smile? Yes No

No

If you could change anything about your smile, what would it be? _____

7

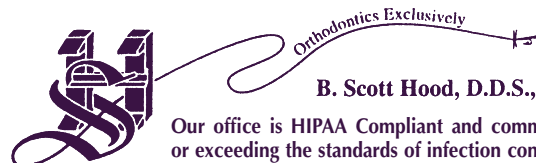
DISCLAIMER

I understand that information I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature _____ Date _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.



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Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I have verbally reviewed the medical / dental information above with the patient named herein: _____

Initials _____ Date _____

Doctor's comments: _____
