Marina View Dentistry

Ioannis Magnis, D.D.S.

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

ABOUT YOU			
Today's date:			
Name:			Male Female
Birth date:	Age:	SS#:	
Address:			
City:	State:		
Driver License #:			
Single Married Divorced Widowed Separated			
Cell Phone #:		Home/Work Phone #:	
Email:			
Employer:			
Occupation:			
When & Where is the best time to reach you?			
Whom may we thank for referring you?			
Previous Dentist:		Last Visit date:	

SPOUSE INFORMATION		
His/ Her Name:		
Occupation /Employer:		
Birth date:	Age:	SS#:

INSURANCE DENTAL COVERAGE		
PRIMARY		
Insurance Co. Name:		
Insurance Co. Address:		
Insurance Co. Phone #:		
Group #:		
Insured's Name:		Relation
Insured's Birth date:		
Insured's SS#:		
Insured's Employer:		
SECONDARY		
Insurance Co. Name:		
Insurance Co. Address:		

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Insurance Co. Phone #:	
Group #:	
Insured's Name:	Relation:
Insured's Birth date:	
Insured's SS#:	
Insured's Employer:	

In the event or an emergency, is there someone that lives near you whom we should contact?

Name:	
Relation:	
Phone #:	

MEDICAL HISTORY					
Do you have a personal Physician?				Yes	No
Name:	Office Phone #:				
Date of last visit:					
You current physical health is:	Good	Fair	Poor		
Are you currently under the care of a Physician?				Yes	No
Are you taking any prescription/ over the counter drugs:				Yes	No
Please list each one:					
For Women, 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 DISEASES OR MEDICAL PROBLEMS?	
Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/ Drug Abuse	Y N Herpes/Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+/AIDS
Y N Artificial bones/joints/valves	Y N Hospitalized for any reason
Y N Asthma	Y N Kidney Problems
Y N Blood Transfusion	Y N Liver Disease
Y N Cancer/Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Pacemaker
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Emphysema	Y N Rheumatic/Scarlet Fever
Y N Epilepsy	Y N Seizures

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Y N Fainting Spells	Y N Shingles
Y N Frequent Headaches	Y N Sickle Cell Disease/Traits
Y N Glaucoma	Y N Sinus Problems
Y N Hay Fever	Y N Stroke
Y N Heart Attack	Y N Thyroid Problem
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Heart Surgery	Y N Ulcers
Y N Hemophilia	Y N Venereal Disease

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

Y N Aspirin	Y N Erythromycin	Y N Metals
Y N Codeine	Y N Jewelry	Y N Penicillin
Y N Dental Anesthetics	Y N Latex	Y N Tetracycline
Other:		

DENTAL HISTORY

Why have you come to the dentist today?	
Do you require antibiotics before dental treatment?	Yes No
Are you currently in pain?	
Have you ever had a serious/difficult problems associated with any previous dental work?	
Yes No Explain:	
Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)?	
Your current dental health is: Good Fair Poor	
Do your gums ever bleed?	Yes No

I understand that the information that I have given today is correct to the best or my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office or 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.

Signature _____ Date _____

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

I understand that I am responsible for payments of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved

OMAC Building - 995 West 7th Street - Oxnard, CA. 93030 - (805) 616.7102

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WRITTEN FINANCIAL POLICY

Thank you for choosing Dr. Yianni Magnis. Our primary mission is to deliver the best and most comprehensive dental care available.

Insurance: We bill insurance as a courtesy and we are happy to assist you in gathering pretreatment information about coverage and submitting and following up on your claim. But we are not agents of the insurance carrier and we cannot compel their payment. We can only request coverage information and act upon it in good faith. Thus our estimate of your coverage, payments and final out-of-pocket expense is never certain. Denials and disappointments can result in spite of verbal approvals or even a written pre-authorization. **If your insurance has not paid within 45 days any unpaid balance is due from you at that time**, even if your claim is still pending. Unpaid balances accrue interest at 1.5% per month. Accounts requiring collection actions are subject to substantial fees.

I agree to pay 25% of the total fee of any appointments broken without 48 hours notice. Treatment plans may change and you understand that you are responsible for the work that is actually done.
For patients without insurance, we offer courtesy 5% accounting adjustments for payment of treatment prior to completion of care in addition to a courtesy 5% accounting adjustment for payment with cash or check.

If you have any questions, please do not hesitate to ask.
We are here to help you get the dentistry you need!

Your signature below indicates that you have read and understood our office policy.

Patient, Parent or Guardian Name and Signature **Date**

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ACNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand and/or have had the opportunity to read this office's Notice of Privacy Practices.

Patient Name

Patient, Parent or Guardian Signature **Date**

ACNOWLEDGMENT OF NOTICE OF DENTAL MATERIALS FACTS SHEET

I understand and/or have had the opportunity to read this office's Notice of Dental Materials facts sheet.

Patient Name

Patient, Parent or Guardian Signature **Date**