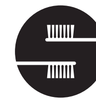
New Patient Registration



Hermes Sotto, D.D.S.

Last Name ______ First Name ______ Middle Initial ______

Address ______ City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Mobile Phone ______

Mobile Carrier ______ Email 1 ______ Email 2 ______

Birthdate ______ Social Security Number ______ CA Drivers License Number ______

Sex M F Marital Status Single ☐ Married Widowed ☐ Divorced ☐ Separated Dom. Partner

Employer ______ Occupation ______

Person responsible for this account? ______ Relationship? ______

In case of emergency, who should be notified? ______ Relationship? ______ Phone Number ______

Whom may we thank for referring you? ______

Primary Insurance Information

Policyholder Name ______ Social Security Number ______ Birthdate ______

Employer ______ Occupation ______ Phone Number ______

Insurance Carrier ______ Policy Number ______ Phone Number ______

Insurance Carrier Address ______

Secondary Insurance Information

Policyholder Name ______ Social Security Number ______ Birthdate ______

Employer ______ Occupation ______ Phone Number ______

Insurance Carrier ______ Policy Number ______ Phone Number ______

Insurance Carrier Address ______

Medical History

Have you ever had the following? (Please choose)

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problem
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves/Joints
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Respiratory Problems
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitus/Liver Disease
- ☐ Sinus Problems
- ☐ Psychiatric Care
- ☐ Hemophilia
- ☐ H.I.V.
- ☐ A.I.D.S.
- ☐ Allergies to Medicine or Drugs
- ☐ Allergies to Latex
- ☐ Allergies to Anesthetics
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Blood Disorders
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Ulcers
- ☐ Fen-Phen Use

Doctor's Comments/Signature/Date ______

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes No If so, what? ______

Have you responded adversely to medical or dental treatment? Yes No If so, what? ______

Are you taking medication at this time? Yes No If so, for what? ______

Are you under the care of a physician? Yes No If so, for what? ______

Physician's Name ______ Phone Number ______

(Women) Are you pregnant? Yes No What trimester are you in? ______ Are you nursing? Yes No

Welcome to Our Practice

In an effort to keep dental costs down while maintaining high level of professional care, we would like to take this opportunity to discuss with you our philosophy and office policy. Please take a minute to read it and if you have any questions, we will be glad to answer them.

Sterilization Procedure
Our office strictly adheres to all state and federal **OSHA** requirements. We heat sterilize all our instruments, including our handpieces and we run a monthly spore test for our sterilizer.

Insurance
There are many types of insurance plans we accept. Because your insurance policy is an agreement between your employer and the insurance company, we can make **NO GUARANTEE** of any estimated coverage or eligibility. While insurance is a benefit, it generally does not cover the entire cost of treatment. We will do our best to maximize your benefits.

Missed Appointment
We respect your valuable time. In order for us to be able to see our patients in a timely manner, we must ask that you respect your scheduled appointment time. If for any reason you find that you cannot keep your appointment, please notify our office **24 hours** in advance, to avoid a $50.00 cancellation fee and a $75.00 cancellation fee for Saturday appointments. **THIS IS STRONGLY ENFORCED**.

Return Checks
There will be a $75.00 fee charged for any check that is returned to us by the bank.

Payment Options
We have several methods of payment in our office. We feel that one will best suit your needs.
1. Cash or Check
2. Visa or Mastercard
3. Up to 12 month free financing through an outside finance company.

Payment is due at the time of service.

Thank you for choosing our office for your dental needs.

Patient’s Signature ______________________________ Date ______________

Sotto Dental
Hermes S. Sotto
Joanne S. Sotto
345 Gellert Blvd. Ste. S
Daly City, CA 94015
650-994-8300

Payments of Service

Full payment is due at the time of service and your insurance company will be billed for reimbursement unless prior arrangements have been made with the office.There will be and interest charge of 1.5% on all unpaid balances after 90 days. There will be a $50.00 cancellation / no show fee on appointments not canceled within 24 hours of their scheduled time and a $75.00 cancellation / no show fee for Saturday appointment.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that may have been made in the completion of this form.

Patient's Signature ______________________ Date ______________

Acknowledgment of Receipt of Notice of Privacy Practices and Dental Materials Fact Sheet

I have received a copy of this office's Notice of Privacy Practices and Dental Materials Fact Sheet as required by law.

Please Print Name ______________________

Signature ______________________ Date ______________