Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Family Status _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Email Add: _____

Home Address: _____
Street Apt #

_____
City State Zip Code

Employer's Name & Telephone#: _____

Employer's Address: _____

Whom may we thank for referring you to our practice? _____

Emergency Contact Name & Telephone: _____

Health & Medical Information

INSTRUCTIONS:

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question is related to my health status, I must discuss the problem with the doctor or a member of the office Staff. I understand that all questions MUST be answered. I have been assured that the information I provide will not be released without my express permission." All questions must be answered and written in INK.

Patient's Initials _____ Dentist's Initials _____

Are you taking any Medications? List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each. _____
_____

Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.

Are you ALLERGIC to any Medication? List all Medication Allergies: _____
_____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____
_____

Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____
_____

Stomach or intestinal disease? _____

Abnormal blood pressure, excessive bleeding, or anemia? _____

Breathing problems, asthma, tuberculosis, or hay fever? _____

Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment _____

Diabetes? _____

Kidney problems or renal dialysis? _____

A stroke, convulsions, or fainting spells? _____

Arthritis or rheumatism? _____

Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____

Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____

Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____

Are you on a special diet? _____ If yes, for what reason and describe._____

Do you smoke?_____ If yes , describe type and quantity. _____

Are you or have ever been under psychiatric treatment? _____

Do you consume any alcoholic beverages? If yes, how much and how often? _____

Are there any other problems about your health of which you are aware? _____

Have you had any prosthetic joint replacement? _____

Are you allergic to latex? _____

Do you ever notice that your feet and/or ankles are swollen? _____

Are you aware of any swollen glands in your neck? _____

Name, address & phone # of your physician _____

Date of last visit to your doctor _____ Purpose of visit _____

Do you suffer from any disability? _____ If yes, describe _____

Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken_____

_____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and maybe fatal.

For Females Only:

Are you pregnant? _____ If yes, when are you due? _____

Are you currently taking any bisphosphonate medication?_____

Dental History

- Have you ever had a local anesthetic? _____
- Have you ever had unfavorable reaction to local anesthetic? _____
- Have you ever had any complications following dental treatment? _____ If yes please explain: ____

_____

- How long since your last Full Mouth X-rays? _____
- How long since your last dental visit? _____ Reason for the visit? _____
- Does Dental Treatment make you nervous? _____

* Had Abnormal Bleeding? _____
* Do your gums bleed on brushing or eating? _____
*Does food catch between your teeth? _____
* Are any of your teeth sensitive to heat, cold, pressure or sweets? _____
* Do you grind or clench your Jaws? _____
* Do you have pain or clicking in the Jaw Joint in front of your ear? _____
* Are there any sores or GROWTHS in your mouth? _____ Where? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of Dentist or Doctor

Financial Notification & Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party _____

Responsible (or Spouse) Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

UNDERSTANDING YOUR DENTAL PLAN

Indemnity or PPO Insurance:
I hereby assign my insurance benefits to be made directly to my doctor for services rendered. I hereby attest that the above insurance information is accurate and that I am responsible for knowing my benefit and/or coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other dentist and insurance carriers upon request for the purpose of payment for dental services and further treatment of care by another specialist. I further agree that a photocopy of this agreement shall be valid as the original. All charges are the direct responsibility of the patient. I understand that the services cannot be rendered on the assumption that charges will be paid by the insurance company. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill. I hereby acknowledge that I have read, understand, and agree to assess, treat, and test.
All members are responsible for payment if found ineligible for benefits.
Cancelled or failed appointments without a 24 hours notice will result in a charge. Please refer to your handbook.

Patient Signature _____ Date _____

Insurance Information

PRIMARY
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code
Insured's **Employer** Name: _____

Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

SECONDARY
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____

Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-Mail Address: _____ Family Status: _____

Consent for Internet Communications

I grant my permission to **Artistic Center for Dentistry** to upload and store confidential patient information including account information, appointment information and clinical information to the secured web site for **Artistic Center for Dentistry**. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand **Artistic Center for Dentistry** and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that **Artistic Center for Dentistry** is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand **Artistic Center for Dentistry** is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the **Artistic Center for Dentistry** web site with my ID and password. I also agree to immediately notify **Artistic Center for Dentistry** of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand **Artistic Center for Dentistry** will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that **Artistic Center for Dentistry** has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand **Artistic Center for Dentistry** will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand **Artistic Center for Dentistry** CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for **Artistic Center for Dentistry**,and grant **Artistic Center for Dentistry** permission to securely upload my patient information to the web site and consent to receiving educational and informative materials and offers via email.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

HIPPA CONSENT

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SECTION A: Uses and disclosures of Protected Health Information

Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information"). We are also required to provide you with this Notice regarding our policies and procedures regarding your Protected Health Information and to abide by the terms of this notice, as it may be updated from time to time.

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment and healthcare operation purposes. We may obtain information to dispense prescriptions and for the documentation of pertinent information in your records that may assist us in managing your medication therapy or your overall health. For treatment purposes, such use and disclosures will take place in providing, coordinating, or managing healthcare and its related services by one or more or your providers, such as when your pharmacist consults with your physician or a specialist regarding your medications, treatment or conditions.

For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, such as when your case is reviewed to ensure that appropriate care was rendered. For reimbursement purposes, your Protected Health Information may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits management, claims administrators and computer switching programs.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement; provider review and training; underwriting activities; reviews and compliance activities; and planning, development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care that you were provided.

We store some of your Protected Health Information in electronic computer files. We backup our electronic records daily off site and employ other precautions to safeguard the integrity of your Protected Health Information. In spite of these precautions it is possible but unlikely that a computer crash or other technological failure could cause the loss of data. In addition reasonable safeguards are employed to protect your Protected Health Information stored on electronic media.

In addition we may contact you to provide refill reminders, health screenings, wellness events, inoculations, vaccinations or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, we may disclose your health information to your plan sponsor. In addition we may contact you for the purpose of fund raising activities. We may use and disclose your Protected Health Information, without your authorization when the pharmacy needs to contact a physician or physicians staff and is permitted or required to do so without individual written authorization. We may use and disclose your Protected Health Information if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.

From time to time we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create Protected Health Information. Business associates are required to comply with all the privacy regulations on your behalf. We may disclose Protected Health Information about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceeding, public health requirements, health oversight activities, and as required by law.

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I,_____,authorize,_____

_____

To release or discuss information related to my medical/dental condition,(including information related to my treatment plan, medication information and/or billing information) to the following named persons.

1._____ 2._____

3._____ 4._____

Please be advised that any person not referred to on this list will not be given any information related to your care. You may change, restrict or expand this list at any time.

Patients Name:_____

D.O.B. _____

Soc. Sec#: _____

Date: _____

Patients Signature: _____

Patient Screening for Aerosol Transmissible Diseases (ATD)

In compliance with Cal-OSHA Title 8, Section 5199, dental facilities must pre-screen patients for aerosol transmissible diseases (ATD). Dental procedures are not performed on a patient suspected or identified as having ATD. In our office we used this form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk.

Do You Have:

A history of Tuberculosis? Yes ☐ No ☐ If yes, please explain: _____

Symptoms of Tuberculosis? Productive cough (>3weeks):

Yes ☐ No ☐ If yes, please explain: _____

Bloody sputum? Yes ☐ No ☐ If yes, please explain: _____

Nightly sweats Yes ☐ No ☐

Fatigue Yes ☐ No ☐

Malaise Yes ☐ No ☐

Fever Yes ☐ No ☐

Unexplained weight loss Yes ☐ No ☐

Flu and Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

_____

Do you have: How long? Explain:

Fever? Yes ☐ No ☐ If yes, please explain: _____

Body aches? Yes ☐ No ☐ If yes, please explain: _____

Runny Nose? Yes ☐ No ☐ If yes, please explain: _____

Sore throat? Yes ☐ No ☐ If yes, please explain: _____

Headache? Yes ☐ No ☐ If yes, please explain: _____

Patient Signature: _____ Date: _____

Smile Analysis Questionnaire

When I see a picture of myself, the first thing I notice about my smile is:
_____

_____ I wish the color of my teeth were whiter.

_____ I wish my teeth were straighter.

_____ I think my smile shows too much space between some of my teeth.

_____ I have often wished I could change some of the features of my smile.

If yes, what would those features be? _____

_____

_____ I don't really know all of the options available for enhancing my smile.

_____ Fees have been concerns preventing me to proceed with the available options to enhance my smile.

Patient Name:_____ Date:_____