,

Welcome to Our Practice

Whom may we thank for referring you to our practice? (Check all that apply)

- ☐ Our Website
- ☐ Yelp
- ☐ Google
- ☐ Referral Card
- ☐ Passing By
- ☐ Insurance Co
- ☐ ZocDoc
- ☐ Groupon
- ☐ Amazon
- ☐ LivingSocial
- ☐ Brighter LA
- ☐ Other

If you checked Other, please provide name of person or source referring you to our practice.

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

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

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Social Security No.

_____

Preferred method of contact

◯ Mobile ◯ Email ◯ Home ◯ Work ◯ Text

In an emergency, who should be notified? Please enter Name and Phone Number below:

,

Employer Information

Responsible Party Information:

Please complete this section if the person responsible for payment is someone other than the patient, or if the patient is under 18.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

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

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

,

Primary Dental Insurance

Insurance Company Name

Name of Subscriber if different than patient (Last, First)

Patient's relationship to subscriber:

◯ Self ◯ Spouse ◯ Child ◯ Other

Subscriber Date of Birth:

Subscriber SS#

ID Number:

Do you have additional dental insurance?

◯ Yes ◯ No

Method of payment for insurance co-payment or missed appointmrnts.

◯ Visa ◯ MasterCard ◯ American Express ◯ Discover

◯ Debit Card ◯ Flex Pay

Last 4 digits of card no.

Medical Insurance (if available)

Medical Insurance Name

Medical Insurance ID#

,

Insurance Authorization:

Benefits
Covered procedures may have co-payments determined by my Insurance plan. I will be informed of all costs prior to the procedure and I will be responsible for the costs of those treatments based on the terms and conditions agreed upon by myself, my insurance plan, and the provider. I understand that my Insurance Plan may not offer coverage for all dental procedures that are recommended. I am responsible for full payment on those treatments and services.

Insurance Outstanding Balance
I understand that my provider will do all due diligence to insure that all treatment rendered will be completed for the estimated fees prior to the start of treatment. Under any of the following circumstances, I am responsible for the balance of dental services rendered:

. Exceeding the annual maximum allowance
. Treatments deemed as non-covered and/or cosmetic by my insurance plan
. Insurance ineligibility at the time treatment is rendered
. Delays in payment or scheduling by patient resulting in non-payment by the insurance
. Abandonment of treatment prior to completion resulting in non-payment by the insurance
. Payments received from insurance and not returned to the office

If insurance reimburses provider for treatment that was already paid for by patient, patient may choose one of two following options:

. Credit kept on file for future treatment, or
. Check returned to Insurance company to be re-issued to patient

Pre-Authorizations
In order to determine benefits for dental procedures, my dental provider will obtain a pre-authorization for those procedures from my insurance carrier. This service is outsourced to a 3rd party billing company. The fee for sending pre-authorizations is the lesser of the projected co-pays or $125 per patient. All payments toward pre-authorization are non-refundable but will be credited in full towards dental treatment co-pays, deductibles, and/or outstanding balances.

The No Insurance No Problem! Plan
For all patients enrolled in the No Insurance No Problem! (NINP) plan, credit card information is placed on file and annually renewed. Patients may choose not to participate in automatic renewal. If there is a lapse in coverage, all warranty on completed treatment will be void.

All new patients subject to a $5 administration fee, regardless of insurance status.

☐ By checking this box, I understand and agree to the above information. This will serve as my electronic signature.

,

Medical History

Indicate which of the following conditions you have or have had. Checking the box will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] AIDS/HIV Positive
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Valve Replacement
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Mitral Valve Prolapse
- [ ] Nervous Disorder
- [ ] Pacemaker
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problem
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers/Colitis
- [ ] Venereal Disease

Medications

Are you currently taking any prescription or non-prescription medications?

◯ Yes ◯ No

If yes, please list all:

Allergies

Drug Allergies:

- [ ] None
- [ ] Penicillin
- [ ] Latex
- [ ] Codeine
- [ ] Sulfa
- [ ] Other

,

Please mark any of the following to indicate a "YES" response to the question:

- [ ] Are you taking or scheduled to take alendronate (Fosamax) or risendronate (Actonel)?
- [ ] Were you treated or scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa)?
- [ ] Have you ever had complications following dental treatment?
- [ ] Are you currently under the care of a physician due to a specific condition?
- [ ] Have you been hospitalized within the last 5 years due to a surgery or illness?
- [ ] Do you use tobacco (smoking or chewing)?

Name of your physician and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

- [ ] By checking this box, I acknowledge that I have reviewed ALL questions/alerts on the Medical History questionaire and have responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Women Only:

Are you pregnant?

- ◯ Yes ◯ No

Are you taking birth controll pills?

- ◯ Yes ◯ No

- [ ] This is to certify that I give my permission to perform a diagnostic x-ray examination. I have been advised that x-ray examinations can be hazardous to an unborn child, and that I will inform the staff in any future appointment if there is any possibility of being pregnant.

  Antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Therefore, I understand that I will need to use some additional form of birth control (besides birth control pills) for one complete cycle, after a course of antibiotics is completed.

,

Consent for Service

Initial/Recall Visits:
I understand the following are to be performed on my initial and recall visits:
Full series x-Rays, intra-oral photography, panoramic x-ray, and/or diagnostic impressions.
Comprehensive exam, Oral Cancer screening, periodontal charting.
Treatment discussion, alternative treatment options, Pros and cons of various treatments, prophylaxis.

Drugs and Medications
I understand that I may receive a local anesthetic and/or other medications. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the normal chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions.

Changes in Treatment Plan
I understand that during treatment, it may be necessary to change, add, or remove procedures, because of pathology/disease process not initially found during the initial oral exam. An example would be decay found closer to the nerve than observed in the initial x-ray or sub-gingival decay found during professional cleaning. I give my permission to the dentist to make any/all changes and additions as necessary.

If delays in treatment are caused by my repeated canceled or missed appointments, changes in the oral cavity during that time may lead to changes in treatment plan. In such cases, I am responsible for all applicable fees.

Missed Appointments
Dental appointments are reserved exclusively for each patient. In the case that I am unable to keep a scheduled appointment, I must inform the office staff via phone or email 24 hours in advance on a business day (Monday - Friday). Failure to do so will result in a $50 miss

Mobile Text Authorization
I hereby give my consent to receive text message reminders on my mobile telephone. These messages will be a reminder of a scheduled appointment date and time, or a notification to make an appointment for my regular follow-up. I understand that I will be responsible for any fees from my mobile phone provider. I also understand that I can request to discontinue this service at any time by placing a request by phone, email, in writing, or in person.

Further, I give my consent to receive monthly email newsletters including specials and health tips. I may unsubscribe from this service at any time.

Warranties on Treatment
Patients who have had restorative treatment (i.e. Fillings, Crowns, Bridges, or Dentures) have a warranty on those treatments as long as all follow up and hygiene appointments are kept. Patients must present for appointments within 30 days of the original date appointments were set in order to keep warranty intact. For any treatment under warranty, patient will only be responsible for lab fees and cost of materials. Periodontal treatments and failure of treatment due to periodontal and/or new carious infections are not covered under treatment warranties.

Notice of Privacy Practices
I acknowledge that I have reviewed the "Notice of Privacy Practices" and understand that my health information will be handled per the federal laws outlined in the Health Insurance Portability and Accountability Act (HIPAA).

☐ By checking this box, I understand and agree to the above information. This also serves as my electronic signature.