

## NOTICE OF PRIVACY PRACTICES

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

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us in writing how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us in writing how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us in writing how to do this.
- We will say “yes” to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

## **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

## **Do research**

We can use or share your information for health research.

## **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

## **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

## **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## **Address workers’ compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers’ compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

### **Contact Information**

Business Support :: (714) 578-6487 :: Monday – Friday 8:00 a.m. to 5:00 p.m. Pacific Time

**Effective Date** – October 1, 2016

**Patient Acknowledgement of Notice of Privacy Practices**

I, \_\_\_\_\_, acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Legal Guardian's Name (if patient is a minor)

\_\_\_\_\_  
Legal Guardian's Signature

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For office use only:

- Patient refused a copy of the Notice of Privacy Practices (NPPs).
- Patient refused to sign Acknowledgement of NPPs.

\_\_\_\_\_  
Print Name (office staff)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Place the completed copy in the patient's chart.

# Informed Consent General Dentistry

Chart # \_\_\_\_\_

**All patients complete 1 thru 4 below, and 5 thru 13 as needed.**

## **1. EXAMINATIONS AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials \_\_\_\_\_)

## **2. DRUGS, MEDICATION AND SEDATION**

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking.

The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: The administration and monitoring of general anesthesia may vary depending on the type of procedure, the type of practitioner, the age and health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment, and consult with your dentist or pediatrician as needed.

(Initials \_\_\_\_\_)

## **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials \_\_\_\_\_)

## **4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials \_\_\_\_\_)

## **5. DENTAL PROPHYLAXIS (CLEANING)**

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials \_\_\_\_\_)

## **6. FILLINGS**

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

(Initials \_\_\_\_\_)

## **7. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth \_\_\_\_\_ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials \_\_\_\_\_)

## **8. CROWNS, BRIDGES, VENEERS AND BONDING**

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials \_\_\_\_\_)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials \_\_\_\_\_)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials \_\_\_\_\_)

**9. DENTURES – COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials \_\_\_\_\_)

**10. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials \_\_\_\_\_)

**11. PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials \_\_\_\_\_)

**12. IMPLANTS**

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials \_\_\_\_\_)

**13. BLEACHING**

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials \_\_\_\_\_)

**14. NITROUS OXIDE**

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials \_\_\_\_\_)

**15. DENTAL BENEFITS**

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist’s recommendation of optimal dental treatment.

(Initials \_\_\_\_\_)

**I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_



# GENERAL HEALTH INFORMATION CHART # \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
LAST FIRST

### DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up  Cleaning  Toothache  Other \_\_\_\_\_ Please list on line below.  
\_\_\_\_\_
2. Are there other conditions of which we should be aware? YES  NO  If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_
3. When did you last visit a dentist? \_\_\_\_\_ 4. What treatment was performed? \_\_\_\_\_
5. Was the treatment completed? \_\_\_\_\_ 6. When were dental x-rays taken? \_\_\_\_\_
7. Did you have a cleaning? YES  NO  8. Have you had gum (periodontal) treatment? YES  NO
9. Have you ever had prolonged bleeding after an extraction? YES  NO  If yes, please specify: \_\_\_\_\_
10. Have you had any problems with past dental treatment? YES  NO  If yes, please specify: \_\_\_\_\_
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open?  
YES  NO  If yes, please specify: \_\_\_\_\_
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ?  
YES  NO  If yes, please specify: \_\_\_\_\_
13. Do your gums bleed easily? YES  NO  14. Do you feel you have bad breath? YES  NO
15. Are your teeth sensitive to hot or cold? YES  NO  16. Would you like your teeth whiter? YES  NO
17. Are you happy with your smile? YES  NO  If no, please explain: \_\_\_\_\_

### MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES  NO  If yes, please specify: \_\_\_\_\_ Dr. Name: \_\_\_\_\_  
Dr. Phone: ( ) \_\_\_\_\_
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? \_\_\_\_\_
3. Are you taking any medications at this time, including birth control? YES  NO  If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_
4. (Women) Are you pregnant now? YES  NO  If yes, how many months? \_\_\_\_\_ Are you nursing? YES  NO
5. Are there any other health problems of which we should be advised? Please specify: \_\_\_\_\_
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL HEART VALVE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEPATITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
FAINTING YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.*

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent if Patient is a Minor) Doctor Signature \_\_\_\_\_

### MEDICAL UPDATE:

1. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
2. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
3. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT INFORMATION

CHART # \_\_\_\_\_

## PATIENT

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Cell/Pager (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

Social Security # \_\_\_\_\_

DL# \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

## RESPONSIBLE PARTY (If same as above, please skip)

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ DL# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

## EMPLOYMENT

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How Long? \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_ Ext. # \_\_\_\_\_

Verified By \_\_\_\_\_ Date \_\_\_\_\_

(Office use only)

## REFERENCES

Name \_\_\_\_\_  
Last First

Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First

Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_

## PERSON TO CONTACT FOR EMERGENCY:

Last \_\_\_\_\_ First \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

## GETTING TO KNOW YOU

Do you have family members who may need dental care?  
If so, please list name & relationship (son, daughter, husband)

1: \_\_\_\_\_ 2: \_\_\_\_\_  
3: \_\_\_\_\_ 4: \_\_\_\_\_

How did you hear about our office? (Check one)

- |   |  |
|---|--|
| <input type="radio"/> Family-Friend (400)   | <input type="radio"/> Insurance Plan (460)       |
| <input type="radio"/> ConfidDent® (440)     | <input type="radio"/> Television (020)           |
| <input type="radio"/> Newspaper (470)       | <input type="radio"/> Radio (030)                |
| <input type="radio"/> Billboard (050)       | <input type="radio"/> Yellow Pages (120)         |
| <input type="radio"/> Flyer-Coupon (490)    | <input type="radio"/> Direct Mail-Postcard (480) |
| <input type="radio"/> Office Sign (420)     | <input type="radio"/> Internet-Website (190)     |
| <input type="radio"/> Office Transfer (430) |  |

I want information in Spanish: YES  NO

## INSURANCE / DENTAL PLAN

Primary:  Insurance  PPO  HMO (Check one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

## INSURANCE / DENTAL PLAN

Secondary:  Insurance  PPO  HMO (Check one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party or Patient  
(Parent if Patient is a Minor)

Date

(COMPLETE BOTH SIDES)

## Smile Design of Santa Clarita

### **APPOINTMENT POLICY**

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time *just for you*. When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment.

We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

We truly appreciate your courtesy of giving us a 48 business hours notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments, allow us to be partners in your dental care.

It is our policy that with less than 48 business hours notice on a change of commitment, a charge of \$75.00 will be applied to your account. We sincerely appreciate your understanding and cooperation with this matter.

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Patient Signature

Date