PATIENT INFORMATION
(PLEASE PRINT)

E. MAIL

PATIENT Name _____ Birth Date _____
LAST FIRST MIDDLE

Referred by _____

If patient is a minor, give parent's or guardian's name _____ Relationship _____

❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address _____ City _____ State _____ Zip _____

S.S. # _____ Cell Phone # _____ Home Phone _____

Employer _____ Position _____ Bus. Phone _____

Bus. Address _____ City _____ State _____ Zip _____

Who should be notified in case of an emergency _____ Phone _____

Name of nearest relative not living with you _____ Phone _____

Purpose of this appointment _____

SPOUSE OR PARENT Name _____ Birth Date _____
LAST FIRST MIDDLE

Employer _____ Position _____ Bus. Phone _____

Bus. Address _____ City _____ State _____ Zip _____

S.S. # _____ Cell Phone # _____

INSURANCE INFORMATION Do you have insurance: ❑ Yes ❑ No If yes, complete the following

Name of Insured _____ S.S. # _____ Relationship _____

Birth Date _____ Insurance Company _____ Group No. _____

Is patient covered by other Insurance: ❑ Yes ❑ No If yes, complete the following

Name of Insured _____ S.S. # _____ Relationship _____

Birth Date _____ Insurance Company _____ Group No. _____

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial agreement must be made in advance. The practice depends upon reimbursement from the patients for the cost 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 service performed without prior financial agreements, must be paid for in cash at the time services are performed. I understand the dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be payed by an insurance company.

A service charge of 1 1/2% per month (18% per annum), (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principle balance on all accounts not paid within 60 days of treatment date. A fee will be charged for appointments cancelled with less than 24 hour notice.

I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of patients examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and / or his staff, I agree to pay, therefore, the reasonable value of the said services to the said Doctors, 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 billed unless objected to by me, in writing, within the time of payment therefore. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute of waiver of any further term of condition. I further agree that in the event that either this office or I institute any legal proceeding with respect to amounts owed by my for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees. I agree to have any issue of dental malpractice decided by neutral arbitration and I give up my right to a jury or court trial.

I grant my permission to you, or your assigns, 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 agree to their content

Signed _____ Date _____

PLEASE COMPLETE BOTH SIDES

Have you ever taken Fosamax, Boniva,
Actonel or any other medications containing bisphosphonates?.....[]YES []NO

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care.
Please answer all questions. Circle **or check Yes** or **No** where applicable.

MEDICAL HISTORY

1. Are you now under the care of a physician? Give name of physician and phone number _____ **Yes No**
   If so, what is the condition being treated? _____
2. Have you ever been hospitalized or had any serious illness or operation? ..... **Yes No**
   If so, please describe _____
3. Are you taking any medicine ❑ Yes ❑ No
   If so, what? _____
4. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... **Yes No**
5. Are you sensitive or allergic to: ❑ Penicillin; ❑ Erythromycin; ❑ Tetracycline; ❑ Sulfa Drugs; ❑ Aspirin; ❑ Codeine; ❑ Latex
   ❑ Other If Other, Please list: _____
6. Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
MVP (Mitral Valve Prolapse)	❑	❑	Asthma	❑	❑	Stomach Ulcers	❑	❑	Thyroid Disease	❑	❑	Leukemia	❑	❑
Heart Murmur	❑	❑	Tuberculosis (T.B.)	❑	❑	Cold Sores	❑	❑	Kidney Disease	❑	❑	Cancer	❑	❑
Rheumatic Fever	❑	❑	Herpes	❑	❑	Bruise Easily	❑	❑	Liver Disease	❑	❑	Tumors or Growths	❑	❑
Joint Replacement	❑	❑	Jaundice	❑	❑	Sinus Trouble	❑	❑	Respiratory Disease	❑	❑	Chemotherapy	❑	❑
Artificial Prosthesis	❑	❑	Hepatitis A-B-C (circle 1)	❑	❑	Difficulty in Swallowing	❑	❑	Sickle Cell Disease	❑	❑	Radiation Treatment	❑	❑
Glaucoma	❑	❑	Venereal Disease	❑	❑	Pain in Jaw Joint	❑	❑	Blood Disease	❑	❑	Other _____	❑	❑
Diabetes	❑	❑	(Syphilis, Gonorrhea)	❑	❑	Allergies or Hives	❑	❑	Mental Disorder	❑	❑			
High Blood Pressure	❑	❑	HIV Positive	❑	❑	Emphysema	❑	❑	Cerebral Palsy	❑	❑			
Heart Condition	❑	❑	Acquired Immune	❑	❑	Arthritis	❑	❑	Epilepsy or Seizure	❑	❑			
Stroke	❑	❑	Def. Synd. (AIDS)			Psychiatric Treatment	❑	❑	Nervous Disorders	❑	❑			
Excess Bleeding	❑	❑	Blood Transfusion	❑	❑	Cortisone Medicine	❑	❑	Fainting Spells	❑	❑			
Hemophilia	❑	❑							Head Injuries	❑	❑			

7. Are you taking any recreational drugs (marijuana, cocaine, etc.)? Do you have any drug addiction? _____ **Yes No**
   please explain _____
8. Are you taking any blood thinner medicine? ❑ Coumadin ❑ Plavix ❑ Etc. _____ **Yes No**
9. Have you taken FEN-PHEN or REDUX or PONDIMIN? ..... **Yes No**
10. Do you wear a cardiac pacemaker, or have you had heart surgery (when)? ..... **Yes No**
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... **Yes No**
    If so, What? _____
12. (Women) Are you pregnant? If so how many months _____ ..... **Yes No**
13. (Women) Do you have any problems associated with your menstrual period? ..... **Yes No**
14. (Women) Do you take birth control pills? ..... **Yes No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... **Yes No**
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... **Yes No**
3. Have you ever had any serious trouble associated with any previous dental treatment? ..... **Yes No**
   If so, Explain? _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last Dental Treatment? _____
6. Does dental treatment make you nervous? ..... **Yes No**
   If Yes, Check ✓ : ❑ Slightly ❑ Moderately ❑ Extremely
7. Would you desire to be pre-sedated? ..... **Yes No**

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

Date _____ Signature _____

Year2
Changes in Health _____
Date _____ Signature _____

Year3
Changes in Health _____
Date _____ Signature _____

Health Questionnaire MUST be updated every year!

REVIEWED BY
YEAR 1
YEAR 2
YEAR 3

DO NOT WRITE IN THIS SPACE

	Year 1	Year 2	Year 3
Date			
BP	/	/	/
Pulse			
Temp			
By			

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and / or drugs. I also acknowledge that I have been provided by display a copy of **DENTAL MATERIALS FACT SHEET** adopted on October 17, 2001, as well as a copy of the "NOTICE OF PRIVACY PRACTICES" taking effect on April 14, 2003, copies of which will be given to me upon my request. All services are rendered and accepted under the terms and conditions printed on the reverse hereof

Signed: _____ Date: _____
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

Fountain Valley Dental Esthetics

17900 Brookhurst Ste. A | FOUNTAIN VALLEY CA, 92708 | (714) 387-4337

Written Financial Policy

Thank you for choosing Fountain Valley Dental Esthetics. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express or Discover Card

  We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Fountain Valley Dental Esthetics requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over $1500. For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer third party financing for treatments over $600.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $75 (or max allowed by insurance) **is charged for patients who miss or cancel** more than 1 time in a calendar year **without 24-hour notice**.

Fountain Valley Dental Esthetics charges $25 for returned checks.

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

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Authorization to Release Medical Information

I authorize this facility to speak to the following family members or my personal representatives regarding: *(check one)*

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, Diagnosis and prognosis records, nurses and doctors notes

□ Only the following types of information:

_____

_____

Medical Information shall only be released to the following persons:

1._____ Relationship_____

2._____ Relationship _____

3. _____ Relationship _____

This authorization form shall remain valid (*check one*)

□ Until revoked in writing

□ Until _____, 20_____

I understand that I may terminate this medical release form. I must notify this facility in writing regarding termination and effective date. I know that I am entitled to receive a copy of this agreement.

Name _____ Date_____

Signature _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any devised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already take action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness _____

Printed Name of Patient or Legal Representatives Witness _____

Date ___/___/_____