We are pleased you have selected us to provide dental care for you and your family.

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

Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street Unit# City State Zip

Home Ph. # (_____)_____ Work Ph.# (_____)_____Cell Ph.# (_____)_____ Marital Status _____

Soc. Sec. # _____-_____ Drivers Lic. # _____ E-Mail: _____

Birthdate ___/____/ ___ Sex __ M____ F____ if patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

School Address _____

Emergency Contact _____

Responsible Party Information

Name _____
Last First Middle

Soc. Sec. # _____-_____ Birthdate _____/_____/_____ Relationship to Patient _____

Residence _____
Street Apt. # City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Ph. # (_____) _____ Work Ph. # (_____) _____ Fax # (_____)_____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____

Soc. Sec. # _____ Birthdate _____ /_____ / _____ Work Ph. # (_____) _____ Fax# (_____)_____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID#_____

Insurance Company_____ Group #_____

Insurance Co. Address _____ Ph. # (____) _____

Insured's Employer _____ Ph. # (____) _____

Do you have dual coverage? Yes ____ No _____ If yes. Please complete the following secondary insurance information.

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID#_____

Insurance Company_____ Group #_____

Insurance Co. Address _____ Ph. # (____) _____

Insured 's Employer _____ Ph. # (____) _____

Dental Information

Do your gums bleed when you brush? Yes No
Are your teeth sensitive to heat or cold? Yes No Pressure Yes No Sweets Yes No
Do you grind or clench your teeth? Yes No
Do you have any fear of dental work? Yes No

Date of last visit _____ What was done at that time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____
_____

How do you feel about the appearance of your teeth?_____

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the last two years? ..... YES NO
3. Are you now taking any medication or drugs? ..... YES NO
   If yes, please list:_____
4. A. Have you taken any medication or drugs during the last two years? ..... YES NO
   B. Have you ever taken bisphosphonate medications for Osteoporosis or other bone loss related issues?.....YES NO
5. Have you been under the care of a medical doctor during the last two years? .....YES NO
   Physician's Name _____ Ph. # ( )_____
   Address _____
6. Are you sensitive or allergic to any medication or anesthetics?.....YES NO
   If yes, please list:_____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure.....	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle)	A	B C
Angina Pectoris	YES	NO	Ulcers.....	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion.....	YES	NO
Mitral Valve prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily.....	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells.....	YES	NO
Drug Addiction.....	YES	NO	Chemotherapy	YES	NO	Nervousness.....	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date _____		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, Shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than ten pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on special diet? ..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
    If yes, please list: _____
15. Do you smoke? ..... YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Guardian Signature_____ Date _____

Print Name _____

CONSENT

1. The undersigned hereby authorized doctor to x-rays, study models, photographs, or any other diagnostic aides deemed appropriately by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for the patient's treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my department is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient _____ Date _____ Witness _____

Print Name _____

Guardian/Responsible Party (if minor) _____ Relationship to Patient _____

Print Name _____Date_____

OFFICE USE: Reviewed by Dr. _____ Date _____

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

* I, _____(patient), acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient Date

**** If patient is a minor, a parent or legal guardian must sign below.**

_____ _____
Name (please print) Signature Date

_____
Relationship to Patient

***** If patient is not a minor, but under the care of a relative, friend, or caregiver; the relative, friend or caregiver sign below.**

_____ _____
Name (please print) Signature Date

_____
Relationship to Patient

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Fairview Dental
3181 Balfour Road Suite T
925-240-7253

Patient Name:
Patient Address:
Patient phone number:
PLEASE READ CAREFULLY

Purpose of consent: By signing this form you will consent to our use and disclosure of your protected health information (PHI) to carry our treatment, healthcare operations and payment activities.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, healthcare operations and payment activities, of the uses and disclosures we may make of your private health information and other important matters about your protected health information. A copy of this notice is available to you, you may have a copy for your own records on request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including revisions at any time by contacting the Office Manager at the office address or phone number (see top of this page).

Right to Revoke:

You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the Office Manager at the office address (see top of this page). Please understand that revocation of this consent which may affect any action we took in reliance of this consent before we received revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.

I, (**print name**) _____, have had full opportunity to read and consider the contents of this form and your notice of privacy practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatment, healthcare operations and payment activities.

Signature _____ **Date** _____

If this consent is signed by a Parent/Guardian of a minor child, or personal representative on behalf of the patient please complete the following:

Parent/guardian or personal representative name (print) _____

Relationship to patient _____

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with the office manager who is our HIPAA Compliance Officer in person or by telephone.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print name _____

Signature _____**Date** _____
YOU ARE ENTITLED TO A COPY OF THIS CONSENT DOCUMENT AFTER YOU SIGN IT, PLEASE ASK IF YOU WOULD LIKE TO RECEIVE A COPY FOR YOUR OWN RECORDS.

Appointment Modification/Cancellation Policy

Appointments

Office visits are booked by appointments only; please call our office at (925) 240-7253. The front desk may ask the reason for your visit. This helps us schedule the appointment time more efficiently. Please arrive 15 minutes early for your appointment. Patients who are late for any appointment may be asked to reschedule at the dental office discretion. Remember to bring a list of all your prescriptions, over-the counter medicines, vitamins and supplements to your dental visit. For our office record, the front office will ask you to fill out a medical form. This will update any new medication you are taking now.

Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best dental care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that **if you must change an appointment, please give us at least 48 hours' notice**. This courtesy makes it possible to give your time slot to another patient who would like it. We understand your time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except in the case of emergency treatment for another patient, you can expect us to be running on schedule. If you are unable to keep an appointment, we ask that you cancel at least 48 hours in advance. If this is not possible, call as soon as you can so that another patient can be given your appointment time.

Missed Appointments (Non-Cancelled)

We understand occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointment. A "No show/Late Cancellation" is defined as missing an appointment without canceling at least 48 hours before scheduled time. **There will be a charge of $50 for a missed or non-cancelled appointment**. **Next missed or non-cancelled appointment will result in a charge of $100**. Insurance will not cover charges for no show/late or late cancellation fees. The charge is in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. We will offer 30 days of emergent care only and transfer your dental records when you find a new dentist.

Payment

Payment is due in full at the time of service no exceptions.

| ---------- | ---------- | ---------- |
| Patient name | Signature | Date |

Handle Me With Care

- ☐ I gag easily.
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain relief is a top priority to me.
- ☐ I don't like shots, or I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ I don't like the dental office smells.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.
- ☐ I have problems with my back.
- ☐ I don't like the chair tipped back too far.
- ☐ I do not like to see dental instruments.
- ☐ I need to talk to you first, without sitting in the dental chair.
- ☐ Other concerns I would like to talk about (Please specify):

_____

_____

_____

_____

_____

_____