PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Information

Date ________ Patient Name: __________________________ __________________________ _______________________
Last First Middle

Home Address: _____________________________________ City:_____________ State:__________ Zip: _______________

Billing Address: _____________________________________ City:_____________ State:__________ Zip: _______________
(if different)

Home Ph. # (____)__________ Work Ph. # (____)_______________ Cell Ph. # (____)_________ Marital Status __________

Soc. Sec. # _____-____________________ Drivers Lic. # __________________ Email: _________________________________

Birthdate ___/___/ ___ Sex __ M___ F___ If patient is minor, please give parents name:_____________________________

Name of nearest relative not living with you: _______________________Relationship: ___________________________

Emergency Contact: ____ Cell Ph. # (____) _______________

Please list the name of your pharmacy, in the event we need to prescribe medication: ________________________

Address: ____

Responsible Party Information

Name: ____________________________ ________________________ ________________________
Last First Middle

Soc. Sec. # _____-__________________ Birthdate _____/______/________ Relationship to patient: ___________________

Residence: _________________________________ City:________________ State: ________ Zip: ________________

Home Ph. # (____) ______________ Work Ph. # (____) ___________ Fax # (____)______________

Employer ____________________________________ Occupation _____________________ No. Years Employed_________

Employer Address: _____________________________________ City:_____________ State:_________ Zip: ___________

Spouse's Name: ___________________________ Birthdate: _____/_____/ __________ Work Ph. # (____) ____________

Employer: ________________________________ Occupation: _________________________ No. Years employed ________

Employer Address: _____________________________________ City:_____________ State:_________ Zip: ___________

Insurance Information

Primary dental insurance: ________________________________ Group #: ___________ Member ID: ___________

Secondary dental insurance: _____________________________ Group #: ___________ Member ID: ___________

Subscriber's Name: _____________________________ Date of birth: ___/___/___ SS #: _____-____________________

Name of your medical doctor: _______________________ Date of last visit to medical doctor: ___________________

Name of previous dentist: ______________________________ Date of last visit to dentist: ________________________

Referred to us by: _____________________________________

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 ___________

Thank you for choosing Fairview Dental. Our mission is to deliver the best and most comprehensive dental care possible. We strive to provide optimal care that is timely, easy and manageable for our patients. Our appointments are on a scheduled, reserved time basis with Dr. Luu and our Hygiene Team.

APPOINTMENTS FOR CHILDREN: We invite one parent to stay with very young children during the initial examination. For future appointments, we request you allow your child to accompany our staff through the dental appointment. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence. For the safety and privacy of all patients, siblings or other children should remain in the reception room with a supervising adult. ***INITIAL***_______

APPOINTMENT SCHEDULING: A deposit payment will be due at the time of scheduling to secure your reserved appointment with Dr. Luu or one of our Hygienist for treatment. The amount of deposit is dependent upon the quantity of appointment time reserved. ***INITIAL***________

*If you choose to cancel and/or reschedule your reserved appointment; we request, you provide the minimum notice of:

2 complete business days' notice in advance for 60-minute appointments
4 complete business days' notice in advance for 90–120 minute appointments
5 complete business days' notice in advance for 3 hour appointments

This notice allows the dental team a minimal amount of time to offer your reserved appointment time to another patient. We must speak with you live to cancel or reschedule an appointment. Messages left after business hours or not personally answered by the dental office staff during our normal business hours Tuesday through Saturday will not be honored.
Our office hours are Tues-Friday 9:30-6pm and Saturday 8-4pm

*A fee of $50 per 30 minutes appointment time reserved will be charged to you for cancelled or failed appointments without adequate minimum notice as described above.

FINANCIAL OPTIONS: We offer many methods of payments to cover your dental expenses. We accept CASH, VISA, MasterCard, DISCOVER, and American Express (There will be a 3% processing fee added when using any debit or credit card). We also have partnered with Care Credit.
*****We will waive card processing fee for those patients that make full payments at the time of service.

CELL PHONE USE IS NOT PERMITTED DURING CHAIR TIME WITH DR. LUU OR OUR HYGIENE TEAM.

RELEASE OF RECORDS: Our office does have a processing fee for **FULL** dental records and a release of records form will need to be signed. Fee is $50

DENTAL INSURANCE AND ACCOUNT BILLING: As a courtesy, we will submit your dental insurance claim to your dental insurance company. Your estimated payment for services is payable at the time of service. Once final benefit payment is received, we will send you a billing statement for any balance due.
Accounts over 30 days from the date of service are subject to a Billing Statement Fee of $5 and may also be charged interest per each additional billing statement. ***INITIAL***_________

In the event your account is past due and sent to collections, you agree to pay for all fees associated with the account collection which is usually 50% of the total outstanding account balance, court costs and attorney fees.

Guarantor Signature: ____ Date: __________________
Print Name of Guarantor: ____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ CAREFULLY

PURPOSE OF CONTENT: By signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out 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.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Office Manager at the office address. 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 name) _____________________________

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.

Fairview Dental
3181 Balfour Road, Suite T
Brentwood, CA 94513

Dental Photography and Media Authorization Form

Patient's name: ________________________________ Date: _______________

Purpose of Photography and Media

During the course of dental care, photographs, videos, or digital images of your teeth, mouth, smile, and/or face may be taken. These images help us document treatment, monitor progress, and improve patient education. With your permission, these images may also be used for educational and promotional purposes to help other patients understand dental procedures and potential treatment outcomes.
Images may be used in the following ways, such as Fairview Dental's website, social media platforms, educational presentations or professional training, printed materials (brochures, flyers, or office displays), and other online or digital marketing materials.

Consent, Authorization, and Revocation

I have read and understand this form and **voluntarily authorize** Fairview Dental and its representatives to use photographs, videos, or digital images taken during my care for purposes including treatment documentation, patient education, professional training, and marketing or promotional materials.

I understand that my participation is **voluntary** and that declining or withdrawing consent **will not affect the quality of care I receive.** I may withdraw this authorization at any time by submitting a written request to the practice; revocation will apply only to future uses of the images and **cannot remove materials already published or distributed.**

☐ I do NOT permit the use of my images for any educational, marketing, or promotional purposes.

Patient's signature: ________________________________ Date: _______________

If patient is under 18 years of age:

Parent/Guardian Name: ________________________________ Date: _______________

Parent/Guardian signature: ________________________________ Date: _______________

Practice representative's 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 the Dr. will say about my teeth and 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 bad reactions to shots.
☐ Please tell me what I need to do about my mouth so I can make an informed decision.
☐ My teeth are very sensitive.
☐ I don't like the sound of the tool picking and scraping my teeth.
☐ 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.
☐ 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 too far back.
☐ I don't 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).

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