Center for Dental Health, La Jolla
8899 University Center Lane #190, San Diego, CA 92122
(858) 546-0100
dentalhealthlajolla.com/

Powered by Dental Intelligence

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:			
Referred by:			

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Medical History

Patient Name	
Are you in good general health?	
Are you being treated for any illness now?	
Your physician's name	
Physician's Address	
Physician's Phone	
Are you taking medication, drugs or pills now?	
Are you aware of having allergic reactions to any medication or substances?	
Have you been hospitalized during the past five years?	
Indicate which of the following you have had, or have at present	
Heart disease, surgery, attack	
Heart defect	
Artificial heart valve	
Heart murmur	

Congenital heart disease	
Mitral valve prolapse	
Rheumatic fever	
High blood pressure	
Chest pain	
Heart pacemaker	
Artificial joints	
TB, emphysema	
Chronic cough	
Asthma	
Arthritis, rheumatism	
Cortisone medication	
Swollen ankles	
Fainting, dizzy spells	
Stroke	
Diet	
Kidney trouble	
Ulcers	
Diabetes	
Thyroid problems	
Glaucoma	
Contact lenses	
Hay fever	
Latex sensitivity	
Allergies or hives	
Sinus trouble	
Psychiatric, psychological care	
Hepatitis	
Radiation therapy	
Cancer	
Chemotherapy	
Tumors	
Venereal disease	
A.I.D.S.	
H.I.V. positive	
Cold sores, fever blisters	
Blood transfusion	
Hemophilia	
Sickle cell disease	
Bruise easily	
Yellow jaundice	

Liver disease	
Epilepsy, seizures	
Use bisphosphonates	
Recreational drugs	
Alcohol	
Have you lost or gained more than 10 pounds in the past year?	
Do you have or have you had any disease, condition or problem not listed?	

For Women Only

Are you pregnant?	
Are you nursing?	
Are you taking birth control?	

Dental History

Patient Full Name	
What is the reason for your visit today?	
Previous dentist name	
Previous Dentist Address	
Previous Dentist Phone	
How often do you have a dental examination?	
How often do you brush your teeth?	
How often do you floss?	
What other dental aids do you use? (Interplak, toothpick, etc.)	
Do you have any dental problem, pain or sensitivity now?	
Do you feel nervous about having dental treatment?	
Have you ever had orthodontic treatment?	
Have you ever had oral surgery?	
Have you ever had periodontal (gum) treatment?	
Have you ever had clicking or popping of jaw?	
Have you ever had joint pain?	
Have you ever had difficulty in opening or closing your mouth?	
Have you ever had mouth odor or bad taste?	
Have you ever had dry mouth?	
Have you ever had food getting caught between your teeth?	
Have you ever had an upsetting dental experience?	
Do you clench or grind your teeth while awake or asleep?	
Do you breathe through your mouth?	
Do you have tired jaw, especially in the morning?	
Do you smoke cigarettes or cigars?.	
Do you chew tobacco?	
Are you satisfied with your teeth’s appearance?	
Would you like to have whiter teeth?	

Is there anything else about dental treatment that you would like us to know?	

Insurance Information

Do you have dental insurance?	
Billing Street Address	
City	
State	
Insured Persons Name	
Insured Persons Birthdate	
Name of Dental group Plan	
Group Number	

Treatment Consent

I understand that I am having any or all of the following treatment done: x-rays, examination, dental cleaning, fillings, inlays/overlays, crowns, bridges, extractions, root canals, dentures, periodontal (gum) treatment, teeth whitening, local anesthesia	

Patient's signature: Date:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge, Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

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PRIVACY POLICY CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE. This information is necessary for our files and will be kept CONFIDENTIAL.

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It is a Federal and State law to maintain the privacy of your health information. This law (HIPAA) requires us to give you notice about your privacy practices, our legal obligations and your rights concerning your health.

Uses and disclosure of Health Information:

We may use and disclose information about your health for the following reasons:

•Treatment purposes: to another dentist, physician, or healthcare provider.

•Payment purposes: to an insurance company, plan administrator, or collection agency.

•Friends and Family: to help pick up prescriptions, medical supplies, x-rays or other health related activities, in the event of contingencies.

•Appointment reminder: to use aids like voicemails, e-mails, postcards, letters, etc.

•Public benefit: As required by law, to report abuse or domestic violence, to health agencies or a court of law, law enforcement officials, military and other federal officials, and State Worker's Compensation laws.

Patient's Rights:

You may request copies of your health information by making a request in writing. Your health information will be kept for a minimum of 6 years; you have the right to request that we amend your health information. This request can be denied, under certain circumstances, based on our professional judgement and experience.

We support your right to the privacy of your health information and we will do everything within our means and reasonable bounds to enforce this.

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8899 University Center Lane, #190

San Diego, CA 92122

Ph. (858) 546-0100

Fax (858) 546-0495

Patient's signature: Date:

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FINANCIAL POLICY

CONDITIONS OF TREATMENT POLICY

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs 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 arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for the 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 paid 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 principal balance on all accounts not paid within 60 days of the treatment date. I understand that the fee estimate listed for this dental case can only be extended for a period of 6 months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his sta, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time, said services are rendered, or within (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 for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

It is our policy to charge $50.00 per 60 minutes for missed appointments with the hygienists and $100.00 per 60 minuets for missed appointments with the Doctor without 48-hour notice. This fee must be paid prior to scheduling any future appointments.

PATIENT ACKNOWLEDGEMENT

I grant my permission to you or assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above financial policy and conditions of treatment and agree to their content.

I have been informed and am aware of the following options in order to fulfill my financial obligation for dental services rendered.

1. Payment by cash at the time of service
2. Payment by VISA, Master Card, American Express, or Discover at the time of service
3. Payment plan set up through Cherry at least one week prior to scheduled services.

The total balance due is the legal obligation of the patient. The estimated amounts are only given as a convenience to the patient.

Patient's signature: Date:

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BROKEN APPOINTMENT OFFICE POLICY

It is our policy to charge $50.00 per 60 minutes for missed appointments with the hygienists and $100.00 per 60 minuets for missed appointments with the Doctor without 48-hour notice. This fee must be paid prior to scheduling any future appointments.

Time has been reserved for you exclusively on our schedule. While unexpected situations may occur from time to time that may cause you to cancel your reserved appointment, please be informed that any appointment cancelled with less than 48-hour notification, or failure to show for your reserved appointment will result in a charge for every 60 minutes of missed time.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Center for Dental Health, La Jolla offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Center for Dental Health, La Jolla will use reasonable means to protect the security and confidentiality of email information sent and received. However, Center for Dental Health, La Jolla cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Center for Dental Health, La Jolla and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Center for Dental Health, La Jolla.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Center for Dental Health, La Jolla, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Center for Dental Health, La Jolla will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Center for Dental Health, La Jolla cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Center for Dental Health, La Jolla and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Center for Dental Health, La Jolla.

Patient's signature: Date: