Welcome to Optima Dental

Complete this form for each new patient or family.

Patient Information

Date: _____

First Name: _____ MI: _____ Last Name: _____

Social Security # (if over 18): _____ Birthdate: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Status: ❑Single ❑Child Sex: ❑Male Home Phone: (___) _____

❑Married ❑Other ❑Female Cell Phone: (___) _____

Patient Employer/School: _____ Email: _____

Who may we thank for referring you? _____

Does the patient have a dental insurance/benefit plan? ❑Yes ❑No

Primary Insurance

Patient Relationship to the Policy Holder: ❑Self ❑Spouse ❑Child ❑Other: _____

Policy Holder Name: _____ Social Security #: _____

Mailing Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone: (___) _____

Insurance Company Name: _____ Phone: (___) _____

Group #: _____ Member ID/SS #: _____

Secondary Insurance

Patient Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Social Security #: _____

Mailing Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Employers Name: _____ Phone: (___) _____

Insurance Company Name: _____ Phone: (___) _____

Group #: _____ Member ID/SS #: _____

Area of concern? _____ Discomfort level (1-10): _____ 10 = Most painful

When was your last dental appointment? _____

Prior Dentist Name: _____ Phone: (___) _____

Date of last dental X-rays: _____ May we request a copy? _____

Have you ever taken antibiotics before dental treatment? _____ Reason: _____

Allergies to medications? _____

Allergies to Latex? ❑ Yes ❑ No Other Allergies: _____

Additional Appointment Information: _____

_____

_____

At what number can someone be reached at between 9:00am and 4:00 pm? (___) _____

Preferred Pharmacy: _____ Phone: (___) _____

Remind Patient/Parent or Guardian to bring a copy of their insurance card and a picture ID or Driver's License

This form was completed by: _____ Date: _____ Time: _____

Insurance information was verified by: _____ Date: _____ Time: _____

DENTAL / MEDICAL HISTORY

Approx. Date of last dental visit:_____ Date of last x-rays: _____
Previous Dentist: _____ Address: _____
Last Dental treatment: _____

Any conditions that apply to your past Dental treatments or Oral health (Check all that apply)

❑ Excessive Bleeding	❑ Nervous during treatment	❑ Jaw Joint Pain / TMJ Disorder
❑ Gums bleed while Brushing	❑ Bad dental Experience	❑ Difficulty Chewing
❑ Hot/cold sensitivity	❑ Food catches between teeth	❑ Recent toothache
❑ Happy with your Smile	❑ Sensitivity to sweets	❑ Pain or Discomfort
❑ Trouble with Flossing	❑ Yellow or stains on teeth	❑ Concern with Oral Cancer

Primary Care Provider: _____
Address: _____
Phone: _____ What is the date of your last visit? _____
Are you taking any medications or drugs? If so, please list: ❑ Yes ❑ No

❑ Aspirin	❑ Nitrous Oxide	❑ Penicillin
❑ Darvon	❑ Erythromycin	❑ Local Anesthetic
❑ Codeine	❑ Tetracycline	❑ Novocain or Xylocaine
❑ Demerol	❑ Valium	❑ Sleeping Pills
❑ Percodan	❑ Scopolamine	❑ Nembutal/Seconal
Please list any other(s):		

Are you allergic to any of the following Medications? (Check all that apply)

Have you ever had any of the following conditions? (Check all that apply)

❑ Heart Condition/Surgery	❑ General Fatigue	❑ Spinal Injuries
❑ Pacemaker	❑ Multiple Sclerosis	❑ Joint Replacement
❑ Circulatory Condition/Problems	❑ Fibromyalgia	❑ Shoulder injury
❑ High blood pressure	❑ Chronic Fatigue Syndrome	❑ Knee injury
❑ Blood Conditions	❑ Lung disease	❑ Arthritis
❑ Anemia	❑ Difficulty Breathing	❑ Heart Murmur
❑ Bleeding problem	❑ Emphysema	❑ Seizures
❑ Stroke	❑ Asthma	❑ Steroid therapy
❑ HIV / AIDS	❑ Psychiatric/Emotional disorders	❑ Cancer
❑ Compromised immune system	❑ Radiation/Chemotherapy	❑ Kidney disease
❑ Hepatitis	❑ Stress	❑ Liver disease
❑ Diabetes	❑ Thyroid disease	❑ Lymphatic Conditions
❑ Headaches/Migraines	❑ Ulcer	❑ Tuberculosis

Are you taking blood-thinning medications, including aspirin, ibuprofen, or Coumadin? ❑ Yes ❑ No
Are you pregnant? (Women) ❑ Yes ❑ No
Are you taking birth control pills? (Women) ❑ Yes ❑ No
When was your last physical? _____
Is this visit a result of accident or injury using workman's comp? ❑ Yes ❑ No
Please list any other medical conditions not addressed:

_____

_____

_____

Signature: _____ Date: _____
(If client is a minor, Parent or Legal Guardian signature)

Patient HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you; however, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

_____

Printed Name

_____ _____

Signature Date

_____

Relationship to patient (if other than patient):

DENTAL TREATMENT CONSENT FORM

Please read and initial items checked below then read and sign the section at the bottom of the form.

Patient Name: _____ Date of Birth: _____

1. Diagnostic and Preventive

I understand that I am having the following work done: ❑X-rays ❑Cleaning ❑Scaling ❑Other **Initials**_____

2. Drugs and Medications

I understand that antibiotics and analgesics and other medications can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). **Initials**_____

3. Nitrous Oxide

I understand that nitrous oxide (laughing gas) provides relaxation making it more comfortable for me to receive dental care with less anxiety. I will be awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes. **Initials**_____

4. Local Anesthetic

I understand there are risks associated with local anesthesia that may affect my body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, and tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes. **Initials**_____

5. Removal of Teeth

Alternatives to removal have been explained to me and I authorize the dentist to remove the following teeth: _____ _____. I understand that removing teeth does not always remove all 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, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days or months), or fractured jaw. I understand 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**_____

6. Crowns and Bridges

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. It is my responsibility to return within one month of tooth preparation for final cementation of the restoration. I realize the final opportunity to make changes in my new crown or bridge will be before cementation. **Initials**_____

7. Dentures, Complete or Partial

I realize that full or partial dentures are artificial teeth, constructed of plastic, metal, and/or porcelain. The complications of wearing these appliances have been explained to me. These include looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures will be the "teeth in wax" try-in visit. 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. **Initials**_____

8. Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the outcome of the treatment. I understand that an undetectable "hairline" crack in a tooth may cause failure, no matter how extensive therapy may be. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise, such as the need for an apicoectomy. **Initials**_____

9. Change 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 restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. **Initials**_____

10. Periodontal Loss (Tissue and Bone)

I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have an effect on my periodontal condition. **Initials**_____

11. Fillings

I understand that care must be exercised in chewing on fillings the first 24 hours to avoid breakage. I understand that a more extensive restoration than originally planned may be due to additional conditions discovered during preparation. I understand any time a tooth is prepared, for any reason, there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring a root canal. **Initials**_____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient/Legal Guardian Signature _____ Date _____

FAMILY DENTISTRY OFFICE AND FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa and Master card. Returned checks will be subject to additional fees (currently $25). Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance.

As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Separated & Divorced Couples with Dependent Children:

It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All Patients must provide an **ID Card** & **Insurance Card** (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Cancellation & Late Policy:

Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 24 hours advanced notice. An answer machine is available for messages left after business hours. A $75 to $100 fee, depending on the amount of time that was reserved for you, will be applied to your account for rescheduling, canceling or failing to show up for your appointment without 24 hours notice.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.*

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ _____

Signature (Patient or responsible party) Date

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. If you would, please **PRINT** and **SIGN** you name bellow,

I, _____, acknowledge I have received a copy of the Dental Materials Fact Sheet from this office.

(If you do not want a copy of the sheet, please inform the front desk personnel)

X _____ _____

Signature of Patient/Legal Guardian Date

If signed by a Personal Representative of the patient, describe the representative's authority to act for the patient.

_____

_____

We attempted to obtain written acknowledgement of receipt of Dental Materials Fact Sheet, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining acknowledgment
- o An emergency situation prevented us from obtaining acknowledgment
- o Other (please specify)

_____

_____