Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Cell Phone _____ Business Phone _____
Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address *(if different from patient)* _____ Home Phone _____
City _____ State _____ Zip _____
Cell Phone _____ Email _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber Name _____ Relation to Patient _____ Birthdate _____
Address *(if different from patient)* _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber Employed by _____ Business Phone _____
Business Email _____
Insurance Company _____ Phone _____
Insurance Email _____
Contract # _____ Group # _____ Subscriber # _____
Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies **(latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

TARZANA DENTAL CARE FINANCIAL POLICY

As your dental provider, we are committed to providing you with the best possible dental care. In order to achieve this goal, we need your assistance and understanding of our financial policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.

FINANCIAL AGREEMENTS/INSURANCE COVERAGE. As a courtesy, we will bill your dental insurance benefits. You will be responsible for all co-pays and treatment not covered by your insurance. We will gladly discuss your prepared treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contract between you and the insurance company. Our office is not responsible for benefits not paid by your insurance company.
- Our office **ESTIMATES** your portion. **This is only an estimate.** For more exact estimate, you may request that we send in a written pre-determination prior to the start of your treatment. Please note that this is a lengthy process that can take 4-6 weeks before the pre-determination is processed by your insurance company.
- Not all services are covered benefits under all contracts. Some insurance plans exclude coverage of certain services or **downgrade services to a less-expensive service** than the service we provide **without prior notice**.
- All charges are your responsibility from the day services are rendered. You may need to contact your insurance company if there are any questions regarding the company's handling of a claim.

MISSED, CANCELLED AND RESCHEDULED APPOINTMENTS AS A COURTESY, WE TRY TO CONTACT ALL PATIENTS TO CONFIRM THEIR APPOINTMENS, HOWEVER, WE MAY NOT ALWAYS BE ABLE TO REACH YOU. We ask that you give us an advanced notice of **two BUSINESS days** when canceling or rescheduling an appointment. Of course, reasonable consideration will always be given to extensive circumstances, such as unforeseen emergencies or illness.

FEES FOR MISSED/CANCELLED/RESCHEDULED APPOINTMENTS WITHOUT 2 BUISNESS DAYS NOTICE

(In the absence of any extreme circumstances)

DENTAL APPOINTMENTS $50

CERTAN LONGER APPOINTMENTS MAY HAVE A HIGHER FEE AND A DEPOSIT TO SCHEDULE AN APPOINTMENT

AS YOUR APPOINTMENT TIME IS RESERVED FOR YOU WHEN YOU SCHEDULE THE APPOINTMENT, YOU ARE RESPONSIBLE FOR THE CHARGE REGARDLESS OF WHETHER OR NOT A COURTESY REMINDER HAS BEEN SUCCESSFUL. We NEVER schedule or pre-schedule an appointment without your consent or knowledge.

If you have any questions about the above information or any uncertainty about your responsibility, please do not hesitate to ask us. We are here to help you.

I have read the and understand the Financial Policy.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgment

I, _____, have received a copy of this office's notice of Privacy Practices

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

"I have received a copy of the Dental Material Fact Sheet as required by Law"

Signature: _____

Date: _____

Patient Screening Form

SAFETY COMPLIANCE EXPERTS
YOUR OSHA COMPLIANCE PARTNER

Patient Name: _____ Patient Temperature: _____

	Phone Screening		In-Office Screening	
	Date:		Date:	
Do you fever or have you felt hot or feverish recently (14 days)?	☐ Yes	☐ No	☐ Yes	☐ No
Have you experienced recent loss of taste or smell?	☐ Yes	☐ No	☐ Yes	☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes	☐ No	☐ Yes	☐ No
Do you have a cough?	☐ Yes	☐ No	☐ Yes	☐ No
Do you have a runny nose?	☐ Yes	☐ No	☐ Yes	☐ No
Do you have a sore throat?	☐ Yes	☐ No	☐ Yes	☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes	☐ No	☐ Yes	☐ No
Are you in contact with any confirmed COVID-19 positive patients?	☐ Yes	☐ No	☐ Yes	☐ No
Have you been tested for COVID-19 in the last 14 days? (Results?)	☐ Yes	☐ No	☐ Yes	☐ No
Have you traveled in the past 14 days?	☐ Yes	☐ No	☐ Yes	☐ No

Watch for symptoms:
People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:
Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea.
This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days. I have also answered the screening truthfully to the best of my ability.

Print Name: _____ Signature: _____ Date: _____