DENTAL DESIGNS
OF ROSEVILLE

1263 Pleasant Grove Blvd., Suite
150 Roseville, CA 95747
phn #: (916) 243 - 6360

Today's Date _____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Ext. _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

PRIMARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY DENTAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

SECONDARY MEDICAL INSURANCE COMPANY:

Insured Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship _____ DOB _____ Sex: ❑ M ❑ F

Mailing Address _____

City _____ State _____ Zip _____

Social Security # _____

Home Tel. (_____) _____ Cell. (_____) _____

Custody / Court Order in Place? ❑ Yes ❑ No

Employer _____

Group Name _____

Insurance Company _____

ID # _____ ❑ PPO ❑ HMO

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? ***Date of last visit*** _____	☐	☐
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☐	☐
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☐
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant / heart valve replacement? ***If so, describe where*** _____	☐	☐
7.	Have you ever had general anesthesia?	☐	☐
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
11. Asthma	☐	☐
12. Difficulty breathing?	☐	☐
13. Other lung problems / cough?	☐	☐
14. A Pacemaker / Heart valve replaced?	☐	☐
15. Heart problems?	☐	☐
16. Chest pain?	☐	☐
17. Irregular heart beat?	☐	☐
18. Heart surgery?	☐	☐
19. Stroke?	☐	☐
20. Trouble climbing two flights of stairs?	☐	☐
21. High or Low Blood Pressure?	☐	☐
22. Sleep Apnea / Use CPAP?	☐	☐
23. Bleeding Disorder?	☐	☐
24. Bruise / Bleed easily?	☐	☐
25. Hepatitis / Liver Disease?	☐	☐
26. Faint easily?	☐	☐
27. Seizures?	☐	☐
28. Thyroid Trouble?	☐	☐
29. Diabetes?	☐	☐
30. Kidney problems?	☐	☐
31. Dialysis?	☐	☐
32. High Cholesterol?	☐	☐
33. Arthritis?	☐	☐
34. Osteoporosis?	☐	☐
35. Prosthetic joint?	☐	☐
36. Stomach ulcers / Reflux?	☐	☐
37. Immune system problems?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
38. Slow healing?	☐	☐
39. Tumor or growth?	☐	☐
40. Cancer / Radiation / Chemo?	☐	☐
41. Eye disease / glaucoma?	☐	☐
42. Mental health problems / anxiety / depression?	☐	☐
43. Developmental Delay?	☐	☐
44. Removable dental appliance?	☐	☐
45. Pain or clicking of jaws?	☐	☐
46. Contagious Disease?	☐	☐
47. Any other condition / problem not listed?	☐	☐
48. Other condition: _____		
49. Do you smoke?	☐	☐
50. # packs / day _____		
51. Do you use alcohol?	☐	☐
52. How much? _____		
53. Illicit Drugs?	☐	☐

WOMEN ONLY: *(QUESTIONS 67–70)*

		Yes	No
67.	Is there a possibility of pregnancy?	☐	☐
68.	Expected delivery date? _____		
69.	Are you nursing?	☐	☐
70.	Are you taking birth control pills?	☐	☐

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO
71. Any kind of medication, drug, pills?		
72. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?		
73. Have you ever taken diet pills?		
74. Any natural product, herbal supplement or homeopathic remedy?		
75. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years?		
76. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:		

77. Please list any medications you are currently taking. Use the back if necessary. Or, if you have a list, please give it to us & we will make a copy.

Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 8 (eight) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe:

_____

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO
78. Local anesthetic (numbing meds.)?		
79. Penicillin?		
80. Other antibiotics?		
81. Sulfa drugs?		
82. Sodium pentothal / Valium / other tranquilizers?		
83. Aspirin?		
84. Amoxicillin?		
85. Codeine or other narcotics?		
86. Other medications?		
87. Latex?		
88. Soy?		
89. Eggs / yolk?		
90. Sulfites?		
91. Do you have any known allergies?		
92. Please list any allergies other than drug allergies:		

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

FINANCIAL RESPONSIBILITY STATMENT

I, the undersigned certify that I am financially responsible for all charges whether or not paid by insurance. I assign directly to Dental Designs of Roseville all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Dental Designs of Roseville to releasae all information necessary to secure the payment of benefits and I authorize the use of this signature on all insurance submissions. I understand that 60 days after the service date my balance due will accrue finance charges of 1.5% per month.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X _____

Signature of patient *(Parent or Guardian if Minor)*

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

HIPPA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent disclosures have been made in reliance upon my prior consent.

I hereby consent that photographs may be taken during my treatment to be used in a manner for medical programs developed on behalf of Dental Designs of Roseville. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond the documentation for my chart.

Services are provided without regard to **sex, race, color, religion, national origin, or disability**.
Initial _____

I give my permission to release information regarding my appointments or account information to _____.

In the event of an EMERGENCY please contact: _____
Name of Emergency Contact

_____ _____
Relationship of Person Phone Number

Patient Name: _____ Date: _____

Patient Signature or Legal guardian: _____

Dental Appointment Cancellation Agreement

In order to maintain an efficient and effective dental facility, we need to ensure that our patients will arrive to their scheduled appointments. **We request a courtesy of 48 business hours** for any change or cancellation of your appointment. This allows us the time we reserve for you in our schedule to be filled by another patient who may have been waiting for this appointment time. We do, however understand that illness and emergencies may occur and we do make exceptions for those rare occasions.

A fee will be charged to your account for not honoring this agreement. For and appointment scheduled with our **Hygienists' or Doctor** the fee will be $50.00 an hour of your scheduled appointment time. A cancellation of **Oral/IV sedation** less than 72 hours before a scheduled appointment time will include a nonrefundable deposit of $500.00

We reserve the time in our schedule in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment.

_____

Patients Signature or Legal guardian Date

_____

Patients Name (Printed)

*Patient Name _____ _____ _____
First Mid Initial Last

Arbitration Agreement

ARTICLE 1

It is understood that all disputes, including but not limited to alleged medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, or any disputes arising out of Patient's relationship with Doctor will be determined by submission to arbitration as provided by California state law and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

a. Parties To The Agreement The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, personal representatives, or executor of Patient's estate. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extend permitted by law.

The term "Doctor" as used in this Agreement includes the undersigned doctor and his professional corporation or partnership, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extend permitted by law.

b. Treatment Covered Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration.

c. Other Doctors (If Applicable) Patient understand that he or she may at times receive treatment form one or more doctors who practice jointly with the undersigned Doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such doctors practicing with the undersigned Doctor will be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable) Patient understands and agrees that, if Doctor treats her during pregnancy, and dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes In the event Patient feels that a problem has arisen in connection with the medical care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b. Method of Initiating Arbitration If the dispute is not resolved by mutual agreement within 90 days of the notice required under Article 3, Subsection(a) of this Agreement, Patient may initiate arbitration by notifying Doctor to the effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that more than two parties participate, parties aligned Doctor shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision. Each party shall pay on-half of the costs and expenses of the arbitration, and each shall separately pay its respective counsel fees, witness fees, and expenses.

c. Applicable Law The arbitration shall be conducted pursuant to California's Uniform Arbitration Act IRCW 6.04A.010-903). Pursuant to RCW 7.04a.170, the arbitrators shall have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law and rules of the State of California.

d. Interpretation of Agreement Any controversy concerning the interpretation or application of this Agreement itself shall also be submitted to arbitration in the manner provided above.

ARTICLE 4

Revocation If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give the undersigned Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from medical services rendered prior to revocation shall be subject to arbitration in accordance with this Agreement.

If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

◯ **I agree to have any and all disputes including, but not limited to, issues of medical malpractice decided by neutral arbitration and I give up my right to a jury or court trail.** *(See Article 1 of this contract).*

Signature _____ Date: _____

Patient, Parent/Guardian