Everlast Dental

A Reputation for Providing Comfortable and Personalized Care in Cosmetic and Family Dentistry

7400 Sunrise Blvd., Ste A • Citrus Heights, CA 95610 Phone (916) 726-1819 • Fax (916) 726-1896

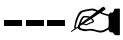
OFFICE POLICY

Welcome to **Everlast Dental**. Our doctors and staff thank you for your continued support. We are here to offer you "State of the Art" dental care. We strive to properly evaluate your needs and to restore your mouth and teeth to proper health. Our goal as a professional dental team is to help you preserve and enhance the health of your teeth. Please read carefully the following:

GENERALS

- For the privacy of the patient ahead of you, please sign-in with receptionist upon your arrival and we will call you when we are ready to see you
- On your initial appointment, necessary X-rays need to be taken in order to evaluate your oral health that will determine your current dental health. An appointment will follow for additional dental treatments as needed.
- If you are pregnant, or suspect you may be pregnant, please advise the receptionist or the doctor before having any x-rays taken
- You will receive a copy of the Dental Materials Fact Sheet for reference and Notice of Privacy Practices and General Dental Treatments informed consent.
- Due to the sensitivity of our equipment, the use of cellular phone and/or pager is prohibited in either reception room, hall way and treatment room
- Smoking and Food are NOT permitted in reception room
- For their safety and comfort, we request that you not bring children to your appointment. If you must bring children please bring someone to watch them during your visit
- For patients who are under aged, parent or legal guardian is required to be present during the treatment
- A signature is required by the responsible party (or parent, or guardian of minor patient, or guardian or conservator of an incompetent, or beneficiary or personal representative of deceased patient) to authorize the Release of Dental Records, Financial arrangement and official documents.

FINANCIAL POLICIES



- Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment Visa, Master, Discovery, Check, Cash, Care Credit and *Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice

- Returned checks will be charged of bank charge fee and an additional fee of $50.00. Any unpaid/past due balances will incur a 1.75% finance charge per day and additional collection fee if applicable.

- We accepts personal check under the following terms and conditions:
  - Make check payable to **Everlast Dental (ED)**
  - Two forms of valid identification must be shown, one of which must be a photo ID such as a valid driver's license, State ID or Military ID, the other a major credit card or similar form of identification.
  - We accept Money Order, Cashier Check or Certified Check.
  - We do not accept 'starter' checks or checks that do not have the name and address of the individual or company making the purchase imprinted on them. P.O. Boxes will not be sufficient. A home or business address must be provided, as well.
  - You check presenter/maker must be willing to provide their driver's license number, phone number and complete home address, or have it imprinted on the check, regardless of whether it is a personal or a company check.
  - We do not accept checks printed with Versa Check software. Only professionally printed checks from a recognized check-printing firm will be honored. We do not accept third-party checks or payroll checks.

PATIENTS RESPONSIBLITIES ---✍

- **Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

- **If we are a contracted provider with your plan**, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.
- **If we are not a contracted provider with your dental benefit plan**, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

- The dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We are as dental care providers and our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. The patient's co-pay and insurance coverage portion is only an estimate that bases upon your dental insurance information given at the time of verification. You will assume responsibility for any residual balance(s) or unpaid portion(s) by your insurance.

- In the event of any dispute by the patient regarding payment for services rendered or the quality of services rendered at our office, patient and dentist agree to submit their dispute to binding arbitration to the American Arbitration Association in Citrus Heights or Sacramento

ELECTRONIC COMMUNICATIONS ---✍

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

As a patient at Everlast Dental, I understand and agree to the use of email communication for the purpose of confirming and discussing appointments, treatment plans, and other pertinent information related to my dental care. I acknowledge that this method of communication carries certain risks, including but not limited to:

- Security: Emails may potentially be accessed by unauthorized individuals.
- Privacy: Although efforts will be made to ensure confidentiality, there may be risks to the privacy of my information.
- Delivery: There is a possibility of technical issues that could lead to non-receipt or delayed receipt of emails.

By signing below, I consent to receive emails from Everlast Dental to the provided email address. I understand that the information communicated via email may include, but is not limited to:

- Appointment reminders
- Treatment plans and Account information
- General communication related to my dental health

I acknowledge that I have the responsibility to inform the office promptly of any changes in my email address. I also understand that it is my duty to check my email regularly and not solely rely on email communication for emergency situations or urgent matters.

I understand that I have the right to withdraw this consent at any time by notifying Everlast Dental in writing.

I agree that the dental office and its staff are not liable for any unauthorized access to information that occurs beyond their control, provided they have taken reasonable precautions to maintain the confidentiality and security of the information.

I have carefully read and understood the contents of this release form and voluntarily agree to its terms.

PERMISSION TO USE PHOTOGRAPH/VIDEO

I, the undersigned, hereby grant permission to Nha An Nguyen DDS Inc DBA Everlast Dental to use my image, likeness, voice, and any other attributes, as captured in photographs and/or video recordings, for the purpose of promotion, marketing, advertisement, and other related activities.

I understand and agree to the following terms:

- **Release:** I grant the Nha An Nguyen DDS Inc DBA Everlast Dental the irrevocable and unrestricted right to use, reproduce, edit, distribute, and publicly display the photographs and/or video recordings, either in whole or in part, without any compensation to me. This usage may include but is not limited to print materials, digital media, websites, social media platforms, presentations, and promotional materials.

- **Confidentiality**: I understand that the general public may view the photographs and video recordings and that Nha An Nguyen DDS Inc DBA Everlast Dental cannot control the further dissemination of these materials.

- **Waiver of Rights**: I waive any right to inspect or approve the finished product wherein my image, likeness, voice, or attributes appear. I also waive any claims to compensation or ownership thereof.

- **Ownership:** I acknowledge and agree that all rights, title, and interest in and to any photographs and video recordings, along with any derivatives thereof, belong exclusively to the Photographer/Videographer.

- **Minors**: If the image, likeness, voice, or attributes of a minor are included, I confirm that I am the legal guardian or parent of the child and have the authority to grant the rights outlined in this release form.

- **Release from Liability**: I release and discharge the Nha An Nguyen DDS Inc DBA Everlast Dental from any claims, liabilities, actions, or demands arising out of or related to the use of the photographs and/or video recordings.

- **No Financial Compensation:** I understand and agree that I will not receive any financial compensation for using the photographs and/or video recordings.

  I have carefully read and understood the contents of this release form and voluntarily agree to its terms.

INSURANCE BILLING POLICY

At Everlast Dental, our objective is to optimize your dental insurance benefits while delivering exceptional quality dental care. We are pleased to extend the courtesy of handling your dental insurance billing for the services provided. Prior to any dental procedure, we are committed to furnishing you with an estimate based on your dental benefits. Every effort will be made to ensure the accuracy of this estimate. However, it's important to note that the actual insurance payment may vary due to factors specific to your plan. The final payment amount is determined by your insurance company and your plan's benefits, subject to various conditions such as limitations, exclusions, waiting periods, frequency limitations, age restrictions, deductibles, and maximums, which are your responsibility to comprehend.

Upon your request, we have the capability to submit a predetermination of benefits to your insurance provider before your dental treatment. While this process may take 6-8 weeks for completion, it's advised not to delay essential dental treatment for this purpose. It's important to highlight that a predetermination does not guarantee the final benefits.

Please be aware that all charges incurred remain your responsibility regardless of your insurance coverage. Our primary relationship is with you, our valued patient, and not directly with your insurance company. Your dental benefit agreement is a contract between you, your employer, and your insurance provider. Regardless of the extent of coverage, your estimated co-payment is expected to be settled in full on or before the day of treatment. Furthermore, dental insurance plans are designed with limitations, and not all dental needs are comprehensively covered.

Recognizing the importance of accurate dental benefit information, it is incumbent upon you to promptly inform our office of any changes to your insurance or any dental services received from other providers. This ensures an accurate adjustment of your remaining dental benefits for estimation purposes and your co-payment. Please note

that the process of collecting and verifying dental benefit information may span several days. Failure to verify your dental benefits before your appointment may necessitate payment for services rendered.

By electing to authorize Everlast Dental to manage my insurance filings, I assume full responsibility for this account and all dental procedures carried out for my family within this dental facility. I understand the importance of being knowledgeable about my specific dental plan. It is also clear to me that the office cannot guarantee full coverage for all services by my insurance company; the provided estimate reflects an approximation of benefits. Additionally, I acknowledge that if my insurance provider does not remit payment within 30 days from the date of service, the financial responsibility will fall on me at that juncture

2-BUSINESS DAY APPOINTMENT CANCELLATION POLICY

Our goal at Everlast Dental is to provide quality dental care in a timely manner. We do understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us at least 2-Business Day Cancellation notice whenever possible if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

We appreciate your understanding and considering our cancellation and failed appointment policy.

- The answering machine or email does not take the cancellation message. **Cancellations must be done over the phone from Monday – Thursday between 8 – 5 pm by speaking directly to one of our dental team members**.

- Here are the examples:
  - **Monday's appointments**: Cancel or Reschedule by **5 pm on Wednesday of the previous week**
  - **Tuesday's appointments**: Cancel or Reschedule by **5 pm on Thursday of the previous week**
  - **Wednesday's appointments**: Cancel or Reschedule by **5 pm on Monday of the current week**
  - **Thursday's appointments**: Cancel or Reschedule by **5 pm on Tuesday of the current week**

- Cancellation or rescheduling of an appointment at least 2-Business Days Cancellation notice or more will result in no charge.

- A failed appointment is an appointment that is canceled or rescheduled for less than 2-Business Day Cancellation notice, or an appointment where a patient does not show up will result in a charge of $100 per appointment.

- After two (2) failed appointments, we may require a deposit of up to 100% that will be applied to your appointment in order to reserve any further appointments.

- As a courtesy, we do call and/or text, and/or email to confirm the date and time of your appointment. If we can't reach you and only leave a message, or cannot reach you at all, please understand that it is your responsibility to remember your appointment dates and times in order to avoid missed appointments and cancellation fees. You are always welcome to call and double-check any appointments if you're unsure.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Everlast Dental as described above.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

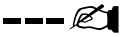
Contact Person: Thomas Nguyen

Telephone: 916-726-1819 Fax: 916-726-1896_____

Address: 7400 Sunrise Blvd, Ste A, Citrus Heights, CA 95610_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

NOTICE OF PRIVACY PRACTICES



This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect 01/01/2020 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations.
For example:

Treatment
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email

We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information.

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in whichyou may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment
You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Thomas Nguyen

Telephone: 916-726-1819 Fax:916-726-1896

Email:Admin@Everlastdental.com

Address: 7400 Sunrise Blvd., Ste A Citrus Heights CA 95610

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Nha An Nguyen DDS Inc., DBA Everlast Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

SIGNATURE

I, undersigned, have had full opportunity to read and consider the contents of this Consent 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, payment activities and heath care operations.

Thank you in advance for observing our office policy. If you have any questions, please do not hesitate to ask the Doctor(s) or any of our staff members. I have read and understand the above information.

I have read and understand the office policy and received a copy of the Dental Materials Fact Sheet and Notice of Privacy Practices as required by law and General Dental Treatments Informed and Consent.

Patient Name **Signature**

CREDIT CARD AUTHORIZATION FORM

Please complete all fields.
You may cancel this authorization at any time by contacting us at (916) 726-1819.
This authorization will remain in effect until cancelled.

Credit Card Information			
Card Type:	☐ MasterCard	☐ VISA	☐ Discover ☐ Other
Cardholder Name (as shown on card):			
Card Number:			
Expiration Date (mm/yy):			
Car Verification number (on back of card):			
Cardholder billing address:			
City:	State:	Zip code:	

I, _____, authorize Everlast Dental to charge my credit card above for agreed upon purchases/dental treatments (see Ortho Payment Agreement if applicable). I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Name **Signature**

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Email address: _____

Social Security #: _____ Birth Date: _____

Phone (☐Home / ☐Cell): _____ (Work): _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Google ☐ Yelp ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

1. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (**Please circle Yes or No for each**)**:**

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Cosmetic surgery	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Emphysema or other lung disease	Yes / No Eating disorders	Yes / No Tuberculosis

2. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

3. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium	Yes / No Tetracycline
Yes / No Darvon	Yes / No Demerol	Yes / No Vicodin
Yes / No Codeine	Yes / No Penicillin	Yes / No Percodan
Yes / No Latex	Yes / No Food	Yes / No Nitrous oxide
Yes / No Local anesthetic (Novocain or Xylocaine)	Yes / No Erythromycin	Yes / No Metal

4. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month?_____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

5. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST 3 MONTHS? (Please circle Yes/No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin

Please list all prescription medications:_____

_____

6. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain:_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:_____

Yes / No Have you ever taken Fen-Phen? If YES, when:_____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

7. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

Yes / No Is your general health good? If NO, explain:_____

Yes / No Has there been a change in your health within the last year? If YES, explain:_____

Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

If YES, explain:_____

Yes / No Are you being treated by a physician now? If YES, explain:_____

Date of last medical exam? Reason for exam:_____

Yes / No Have you had problems with prior dental treatment? If YES, explain:_____

Date of last dental exam: Name of last treating dentist:_____

Yes / No Are you in pain now? If YES, explain:_____

Consent for Services

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

As a condition of your treatment by this office, 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

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. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, 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 five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient (Parent or Guardian):_____ Date:_____

Signature of Dentist:_____ Date:_____