Redondo Beach Dental Group

THE FINE ART OF DENTISTRY

PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Patient's Name_____ Age_____ Date of Birth_____
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian_____ Relationship_____

How did you hear about us?_____

Residence Address_____
STREET CITY ZIP

Patient is: _____Married _____Single _____Divorced _____Separated _____Widowed _____Minor Gender: _____Male _____Female

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security No._____ Driver's License No._____ E-mail Address_____

Employed by_____ How Long?_____

Business Address_____
STREET CITY ZIP

Spouse's Name_____ Driver's License No._____ Social Security_____

Cell Phone_____ Work Phone_____ Employed by_____ How Long_____

Business Address_____
STREET CITY ZIP

Name of nearest relative not living with you._____ Relationship_____ Phone No._____

Complete Address_____
STREET CITY ZIP

Name of General Physician_____ Phone No._____

Name of Additional Physicians_____ Phone No._____
NAME TYPE OF PHYSICIAN

Former Dentist_____ Phone No._____
NAME CITY OF OFFICE

Reason for changing dentists_____

Purpose for this appointment_____

Financial Information

Person Responsible for this account_____ Relationship_____ (___)_____
TELEPHONE

Address_____ (___)_____
STREET CITY ZIP CELL PHONE

Name of Insurance Co. (Primary)_____ Group Number_____

Insured Person's Name_____ DOB:_____ SS#_____ Relationship_____

Name of Insurance Co. (Secondary)_____ Group Number_____

Insured Person's Name_____ DOB:_____ SS#_____ Relationship_____

Signed:_____ Date:_____

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Health Questionnaire

These questions are for your benefit and to assure that our treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Medical History *Please answer each question and circle Yes or No where applicable.*

1. Are you in good health? ..... **Yes No**
2. Date of last physical exam _____
3. Are you now under the care of a physician? ..... **Yes No**
   If so, what is the condition being treated _____
4. Have you ever had any serious illness or operations ..... **Yes No**
   If so, what illness or operations _____
5. Have you ever been hospitalized? ..... **Yes No**
   If so, What was the problem? _____
6. Do you have or have you had any of the following: (please circle "**Y**" for Yes or "**N**" for No - answer all conditions):

Y N Anemia	**Y N** Glaucoma	**Y N** Sleep Apnea	**Y N** Angina Pectoris	**Y N** Pain in Jaw Joint	**Y N** Psychiatric Treatment
Y N Herpes	**Y N** Tonsillitis	**Y N** Snoring	**Y N** Mental Disorder	**Y N** Artificial Prosthesis	**Y N** Hepatitis or Jaundice
Y N Stroke	**Y N** Hemophilia	**Y N** Heart Murmur	**Y N** Thyroid Disease	**Y N** Sickle Cell Disease	**Y N** Difficulty Swallowing
Y N Ulcers	**Y N** Cold Sores	**Y N** Liver Disease	**Y N** Fainting Spells	**Y N** Cortisone Medicine	**Y N** Congenital Heart Lesions
Y N Diabetes	**Y N** Emphysema	**Y N** Blood Disease	**Y N** Rheumatic Fever	**Y N** Allergies to Metal	**Y N** Osteoporosis
Y N Arthritis	**Y N** Rheumatism	**Y N** Heart Ailments	**Y N** Tuberculosis (T.B.)	**Y N** Excessive Bleeding	**Y N** Are you taking Humira
Y N Asthma	**Y N** Heart Attack	**Y N** Blood Transfusion	**Y N** Mitral Valve Prolapse	**Y N** Radiation Treatment	
Y N Cancer	**Y N** Bruise Easily	**Y N** Cerebral Palsy	**Y N** Low Blood Sugar	**Y N** High Blood Pressure	
Y N Seizures	**Y N** Head Injuries	**Y N** Drug Addiction	**Y N** Joint Replacement	**Y N** Low Blood Pressure	
Y N Hay Fever	**Y N** Heart Failure	**Y N** Kidney Disease	**Y N** Nervous Disorders	**Y N** Respiratory Disease	
Y N Headaches	**Y N** Scarlet Fever	**Y N** Chemotherapy	**Y N** Tumors or Growths	**Y N** Epilepsy or Seizures	
Y N Implants	**Y N** Sinus Trouble	**Y N** Stomach Ulcers	**Y N** Allergies or Hives	**Y N** X-Ray or Cobalt Treatment	
Y N Venereal Disease		**Y N** HIV or Aids	**Y N** TMJ (Temporomandibular Joint Disorder)		

7. Do you have any disease, condition or problem not listed that you think we should know about? ..... **Yes No**
8. Do you wear a cardiac pacemaker, or have you had heart surgery? _____ **Yes No**
9. Do you smoke? If yes, how much? _____
10. Do you use recreational drugs? If yes, what kind? _____
11. Have you ever taken ____Fen Phen____Redux ____Fosomax ____Zometa ____Actonel ____Boniva ____Aredia ____Diet Drugs ..... **Yes No**
12. (Women) Are you pregnant? If yes, how many months? _____
13. Are you a victim of domestic violence? Do you need help? ..... **Yes No**

Dental History & Airway Focused Dentistry *Please circle "Y" for Yes or "N" for No for any conditions that might pertain to you.*

1. Have you ever had any unfavorable reaction to dental anesthetic? ..... **Yes No**
2. Are you sensitive to epinephrine? _____ **Yes No**
3. Have you had any serious trouble associated with any previous dental treatment? ..... **Yes No**
   If so, explain? _____
4. Does dental treatment make you nervous? ____Slightly ____Moderately ____Extremely ..... **Yes No**
5. Would you desire to be pre-sedated? _____ **Yes No**
6. Do you snore or does anyone in your family snore? ..... **Yes No**
7. Do you feel tired during or at the end of the day? _____ **Yes No**

Y N Morning Headaches	**Y N** Difficulty Concentrating	**Y N** Need Caffeine Throughout The Day	**Y N** Frequent Neck Soreness
Y N Forgetfulness	**Y N** TMJ Disorder	**Y N** Frequent Nightly Awakenings	**Y N** Difficulty Initiating Sleep
Y N Insomnia	**Y N** Bruxism/Grinding Teeth	**Y N** Gerd/Acid Reflux	**Y N** Dry Mouth At Night /Awakening
Y N Need To Urinate During The Night		**Y N** Regular Use Of Sleep Aid	

Current Medications/Supplements

- _____
- _____
- _____
- _____
- BP_____/_____Pulse:_____**Provider:**_____

Allergies

Are you allergic to:

Penicillin ..... Y N
Erythromycin ..... Y N
Tetracycline ..... Y N
Nsaids ..... Y N
Latex ..... Y N
Shellfish ..... Y N
Iodine ..... Y N
Other: _____

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will , without fail, inform the doctor at my next appointment.

Signed:_____ ***Date:***_____

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Welcome! Thank you for choosing us as your dental health care providers! Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Our primary goal is to provide you with the personalized, quality care you deserve and to deliver a smile you truly love. As part of our commitment to you, we will make every effort to make the cost of treatment affordable and will insure you receive the quality care you need or desire. We strive to help you understand your insurance plan and the benefits available to you and make it possible for you to receive your maximum insurance benefits available. Our policy is to calculate, estimate and inform you of all possible costs before we perform any treatment. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We abide by fees that are the usual and customary rates for our area. We will be sensitive to your financial circumstances and do everything possible to help you achieve optimal oral health. Ultimately, however, you are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates and any coverage limitations.

Financial Agreement:

Treatment plans are good 6 months from the date issued. After that period fees and financial arrangements are subject to change.

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service.

Treatment can change due to unforeseen and unpredictable circumstances that can arise once a procedure is started. There will be a fee for any additional procedure NOT included in the original treatment plan.

Payments may be made using cash, check, or credit card. We also partner with CARECREDIT and THE LENDING CLUB to offer additional financing options to our patients. Ask for an application.

Optional payment terms:

1. Pay in full cash discount: We offer a 5% accounting courtesy for all services over $500 that are paid in full on the date of service for those who do not have dental insurance.

2. Pre- Pay discount: If you choose to prepay for services 48 hours prior to your reserved appointment we will extend a 10% courtesy discount with cash or check. A minimum of $1500 patient portion is required. Available for those patients who do not have dental insurance.

3. In office payment plan: We offer a courtesy 3 month interest free automatic payment plan with a credit card on file. Arrangements must be made prior to your reserved appointment.

4. Term Loan: By arrangements with CARECREDIT and/or THE LENDING CLUB we can offer patients upon approval, an interest-free term loan (up to 24 months) with no down payment, no annual fee and no prepayment penalty.

For our patients with Insurance:

As a courtesy to our insured patients, we obtain your plan benefits and submit claims to your insurance company free of charge. We are here to help you receive your maximum benefit available.

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www.redondobeachdentalgroup.com

However, if your insurance company has not reimbursed our office within 90 days of services rendered, you, the patient, are then responsible for any outstanding balance.
We urge our patients to follow up and pursue any outstanding claims 90 days or older. We find that when the patient gets involved with their pending claims the insurance company tends to be more responsive. We will provide you with all current documentation in order to assist you with your inquiries.
If you visit another office, whether it be for an emergency or a referral, it is your responsibility to notify our office of any insurance used in that office and any plan or benefit changes.
We will mail monthly statements to all patients with an outstanding balance including a charge of 1.5% per month after 60 days.
I hereby authorize my insurance company to directly reimburse Redondo Beach Dental Group for services rendered to me under my insurance policy.

Appointments:
In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute.

When you schedule an appointment at our office, we consider it a commitment that the time will work with your schedule. If a scheduled appointment will not work as you had planned, we appreciate and anticipate that you will contact us as soon as possible. We request a 48 business hour notice which will allow us enough time to appoint another patient in your place. We reserve the right to charge a fee if this policy is not respected and we are unable to appoint another patient waiting for care or if you miss your appointment. Hence, there may be a fee of $60 for each hour of the total appointment time missed or cancelled inside a 48 business hour notice.

We do not penalize for unavoidable situations and emergencies. However, we do want to strongly discourage repeated abuse of our scheduling process out of respect for our doctors, assistants and hygienists who are ready and expecting you. After 3 missed or cancelled appointments we may request you seek your dental care elsewhere.

We will attempt to communicate with you in multiple ways to remind you of your reserved appointments. We will mail postcards one month prior to your regular recall and hygiene visits, email you one week prior to your appointment and call or text, if you so choose, 48 and 24 hours before your appointments. If you confirm your appointment online we will forgo calling you directly. We always appreciate you taking a moment to return our calls to let us know that we can count on you to be at your reserved appointment.

If you have any questions about this policy please do not hesitate to let us know, as we welcome any and all communication.

Please indicate your understanding and acceptance of these scheduling and financial policies by signing below.

_____ _____

Patient Signature Date:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

Notice of privacy practices (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The health Insurance portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for cover entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment means** providing, coordinating or managing health care and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- **Payments means** such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointments reminders or information about treatment alternatives or other health-related benefits and services that may be interested to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice form upon request.

This notice is effective as of 11-18-2015 and we are required to abide by the terms of the notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Patient Copy