Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

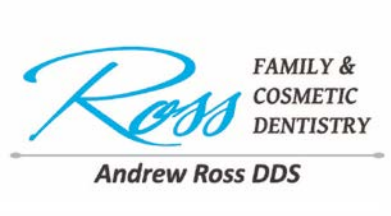
X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____



Important Facts Regarding Our Practice

CANCELLATION or BROKEN APPOINTMENTS:

Our time is as valuable as yours and the other patients scheduled to come in. We are able to extend a "no charge" fee to our patients who give our office a 24 hour courtesy notice if an appointment needs to be changed or canceled. Patients who do not give our office this courtesy will be assessed a $45.00 charge for each appointment missed.

INSURANCE INFORMATION:

As a courtesy to our patients, we will gladly bill your dental insurance carrier free of charge, but understand that any portion that is not covered by your insurance carrier will be your responsibility. In order to properly bill your insurance carrier for our services, we ask that you do the following:

- Bring your dental insurance card and/or information to each dental appointment.
- Notify us with any insurance related change or additional coverage.
- Be knowledgeable about the benefits, effective dates and yearly maximums of the insurance coverage provided to you, your spouse, and/or your dependents.

We are only able to estimate what insurance will pay for certain procedures; we have no way to guarantee payment because the contract is between you and your insurance carrier. An estimate of your dental service charges will be given to you before any treatment is performed.

FINANCIAL POLICY:

We strive to keep our office fees as reasonable as possible for our patients. Payment is expected due on the day that the services are rendered. We also ask that all patients with dental insurance carriers take care of their portion not covered by their insurance carrier on the day that services are rendered (*unless* other arrangements have been made in advance).

Thank you, and Welcome to our Practice!

_____ _____

Patient Name (Printed) **Guardian Name (Printed), if patient is a minor**

_____ _____

Patient or Guardian signature **Date**

Notice of Privacy Practices for Protected Health Information

Ross FAMILY & COSMETIC DENTISTRY
Andrew Ross DDS

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your information for health care operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, payment financing and collection services, and insurance carriers. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our HIPAA Compliance Officer, Sarah, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy and security of your health information as required by law;
- Inform you promptly if a breach occurs that may have compromised the privacy or security of your information;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Sarah, HIPAA Compliance Officer, at (559) 723-3972.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Sarah. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address, phone, and e-mail address is:

Federal Office Building
50 United Nations Plaza – Room 322
San Francisco, CA 94102,

Phone: (415) 437-8310
E-mail: www.hhs.gov/ocr/hipaa and follow directions for e-mail

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Teaching and Education

We may disclose diagnostic aids (radiographs (x-rays), study models, photographs, etc) for teaching and educational purposes.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

This Notice is on the website under new patient forms.

_____ _____

Patient Name (Printed) **Guardian Name (Printed), if patient is a minor**

Acknowledgement of Receipt, Review, and Consent of Privacy Practices

I have received a copy of the dental practice's Notice of Privacy Practices for protected health information (PHI), dated on September 2016, which explains how my PHI will be used and disclosed at this practice for purposes of treatment, payment, and health care operations. I understand I have certain rights to privacy regarding my PHI given to me under the Health Insurance Portability and Accountability Act of 1996. I have been given the opportunity to ask any questions I may have regarding this Notice, and understand that by signing this consent I authorize the dental practice to use and disclose my PHI as specified in this Notice.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payments, and health care operations, but you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that the terms of this Notice my change at any time and that a current copy may be obtained at any time upon my request by calling the office. I further understand I may revoke this consent in writing at any time.

_____ _____

Patient or Guardian signature **Date**

Authorization for Insurance Carrier Billing & Payment

I hereby authorize the dental practice to release any dental information to my insurance carrier(s) that is necessary for billing purposes. I further authorize and assign to the dental practice all payments for dental services billed from this office. I understand that I can withdraw my consent in writing at any time.

_____ _____

Patient or Guardian signature **Date**

Authorization for Cell Phone and/or Email Communication

Check all that apply:

___ I consent to the dental practice using my cell phone number to call and/or text message regarding my treatment, insurance, and account information. I understand that I can withdraw my consent in writing at any time.

___ I consent to the dental practice using my email account to send information regarding my treatment, insurance, and account information. I understand that I can withdraw my consent in writing at any time.

_____ _____

Patient or Guardian signature **Date**

Appointment Reminders

To make it more convenient for you to communicate with our office, we can send appointment reminders and promotional information via personal email and/or text messages to your personal cell phone.
Please send this information using (*check all that applies*):

___ Cell Phone **___** Email **___** Conventionally - Postcards mailed to my home address

Receipt of Dental Materials Fact Sheet

I confirm that I have received the Dental Materials Fact Sheet, dated May 2004. **Initials & Date: _____**

TREATMENT AND FINANCIAL CONSENTS

Treatment

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by Dr. Ross and to all diagnostic methods deemed appropriate by him which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize Dr. Ross to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others, such as designated staff, in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I agree to the use of antibiotics, anesthetics, sedatives, pain medications and other medications as necessary, with the understanding that each of these medications has the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I inform Dr. Ross and the staff all of the medications I am current taking. Medications can cause allergic reactions causing redness and swelling of tissues, discomfort, itching, vomiting and/or anaphylactic shock (a severe allergic reaction that can sometimes become life threatening). I have informed Dr. Ross of all known allergies. Medications may cause headaches, dizziness, drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs, or by increasing the prescribed dose. I understand and fully agree not to operate any vehicle or hazardous device until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I am aware that injecting drugs into the body carries with it the risk of creating hematomas (a blood vessel ruptures and creates a localized swelling of blood), and in rare cases can cause a large swelling and bruise that is unsightly and can take several weeks before it completely goes away. Local anesthetics containing epinephrine are generally considered very safe, but can increase increases blood pressure and can trigger heart arrhythmias, strokes, and heart attacks in patients with compromised cardiovascular systems. Therefore, it is extremely important to keep Dr. Ross updated with your current medical history.

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 routine restorative procedures. I give my permission to Dr. Ross to make any/all changes and additions as necessary.

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position for dental treatment. Although the symptoms of the joint associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

Financial

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by Dr. Ross and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods that are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance carrier or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance carrier or managed care company for any reason (including but not limited to the insurance carrier or managed care company declining coverage after initially approving it) or if the insurance carrier or managed care company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist.

I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $30 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at a rate of 1.5 percent (1.5%) per month (this has an equivalent rate of 19.562% APR) and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's or designated staff's use and disclosure of my health information to my insurance carrier or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance carrier and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

_____ _____

Patient Name (Printed) **Guardian Name (Printed), if patient is a minor**

_____ _____

Patient or Guardian signature **Date**