NEWPORT BEACH DENTISTRY

1401 AVOCADO AVENUE, SUITE 209 • NEWPORT BEACH, CA 92660 • TEL: 949-644-9181 • FAX: 949-644-0521
email: info@dentistryofnewportbeach.com • www.dentistryofnewportbeach.com

Name_____ Male ☐ Female ☐

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____ Date of Birth_____

Occupation_____ Employer_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone Number_____

Person responsible for dental investment ☐ Self ☐ Parent ☐ Spouse ☐ Other_____

Responsible Party's Name_____ Contact Phone Number_____

For Insurance Purposes:

Name of Policy Holder_____ Date of Birth_____

Relationship to Patient_____ SSN_____

Member I.D._____ Employer_____

Insurance Company_____

Insurance Company Number_____ Group Number_____

HIPAA Compliance Statement

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist and business office staff. We may include your health information with an invoice to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. Your health information may be reviewed during the routine process of certification, licensing, credentialing activities or auditing for quality assurance.

Communication with our patients is an important part of our philosophy. We prefer to communicate with you directly but we may incorporate the use of phone messages, postcards and letters. We will make every effort to respect your privacy and honor your request for confidentiality. If you have special needs with regard to privacy issues, please put them in writing for the office so that we may address your concerns.

Financial Information

I have read and truthfully answered the above questions to the best of my knowledge. I authorize the doctor and/or staff to release all information necessary to secure payment of my benefits from my insurance company.

I understand that fees may vary at the time of service due to the extent of treatment. Fees are estimates only and are not a guarantee of payment by my insurance company. I understand that payment of this account is my responsibility, regardless of the amount my insurance company reimburses before or after payment is made.

Patient Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

NEWPORT BEACH DENTISTRY

MEDICAL HISTORY

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Patient Name _____ Nickname _____ Age _____
Name of Physician and their Specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last 6 months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired hear defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5)	☐	☐
13. emphysema, shortness of breath, sarcoidosis	☐	☐
14. tuberculosis, measles, chicken pox	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (ie sleep apnea, snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c = _____)	☐	☐
24. stomach or duodenal ulcer	☐	☐
25. digestive disorders (ie celiac disease, gastric reflux)	☐	☐
26. osteoporosis/osteopenia (ie taking bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. autoimmune disease (ie rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (ADD/ADHS, prion disease)	☐	☐
34. viral infections and cold sores	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI / STD / HPV	☐	☐
38. hepatitis (type_____)	☐	☐
39. HIV / AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. emotional difficulties	☐	☐
44. psychiatric treatment	☐	☐
45. antidepressant medication	☐	☐
46. alcohol / recreational drug use	☐	☐
ARE YOU:		
47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (ie fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches	☐	☐
53. a smoker, smoked previously or use smokeless tobacco	☐	☐
54. considered a touchy / sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (ie Botox, Collagen injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Patient Signature: _____ Date: _____
Doctor Signature: _____ Date: _____

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DENTAL HISTORY

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Patient Name _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist_____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays __/_____/_____
Date of most recent treatment (other than a cleaning) ____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely
WHAT IS YOUR IMMEDIATE CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [_____]_____ ☐ ☐
2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had complications form past dental treatment?_____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed?_____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?_____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family?_____ ☐ ☐
11. Have you ever experienced gum recession?_____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?_____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____ ☐ ☐
16. Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth?_____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?_____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line?_____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
20. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____ ☐ ☐
23. Do you avoid or gave difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped?_____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose?_____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore?_____ ☐ ☐
31. Do you have any problems with sleep (ie restlessness), wake up with a headache or an awareness of your teeth?_____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth?_____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work?_____ ☐ ☐

Patient Signature:_____ Date:_____
Doctor Signature:_____ Date:_____

NEWPORT BEACH
DENTISTRY

Newport Beach Dentistry Consent & Office Policy

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I understand that at any time during my dental treatment, unforeseen changes in my treatment plan may be necessary. The dentist will keep you informed during the process of any changes that could occur during treatment including but not limited to removal of decay and/or crowns and/or fillings.

5. If you have insurance it is a contract between you and the insurance company. We will make every effort to assist you with your insurance and will prepare and submit insurance claims for you. We will estimate what the insurance company will pay and you will be responsible for any estimated co pays at the time of service. If your insurance pays less than what was estimated, you will be responsible to pay any remaining portion.

6. To assure that you receive the best dental care in an efficient and timely manner we reserve appointments exclusively for you. We ask that if you need to change or cancel an appointment, at least 48 hours notice must be given or you may incur a $50 per hour cancellation fee. If an appointment is cancelled or failed multiple times a deposit may be required to reserve your future appointments.

7. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

Print Name

_____

Relationship to Patient (if not signed by the patient)

NEWPORT BEACH
DENTISTRY

Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

Full payment is due at time of service. We accept cash, checks, Visa, Mastercard, Discover, American Express credit cards, and debit cards.

Regarding Insurance
We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

Adult Patients
Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when you arrive for you appointment.

Minor Patients
The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at time of service has been verified.

Billing
All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

Refunds
Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

NEWPORT BEACH
DENTISTRY

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

Print Name

_____

Relationship to Patient (if not signed by the patient)

Disputes

I agree to resolve any disputes through arbitration only. **Initial: _____**

I understand dentistry is not exact science and therefore practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist is responsible for my treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for any & all outstanding payment of dental fees. I agree to pay any attorney fees or court costs that may be incurred to satisfy this obligation. I have read, understood and agreed to the above. I am of legal age and legally competent to make this agreement.

By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

Patient Signature: _____ Date: _____

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LATE CANCELLATION OR NO SHOW GUIDELINES

We make every effort to give patient appointments which fit their schedule as well as our own. Our office cancellation fees are only intended as a courtesy for our professionals' time dedicated to our field. **Our office fee for a missed appointment is $100.00 per hour booked.** We hope our patients keep their appointments as these fees do not offset our losses when a patient does not keep an appointment.

By informing us of your cancellation within 48 hours, you'll be giving a chance to those individuals who are truly in need of seeking dental care.

By signing below, I am acknowledging that I have read and understand this office policy,

Patient Signature: _____

Date: ____/____/____

NEWPORT BEACH
DENTISTRY

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Newport Beach Dentistry's Notice of Privacy Practices, which has an effective date of 2/16/15, and which describes how my health information may be used and disclosed.

I understand that Newport Beach Dentistry has the right to change the Notice of Privacy Practices at any time. I will be provided a copy of the updated version and may also contact the Policy Officer at any time to request a current Notice of Privacy Practices.

By signing below, I acknowledge that I have read the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

Print Name

_____

Relationship to Patient (if not signed by the patient)

_____

Name(s) of Family Member(s) or Representative(s) that Newport Beach Dentistry can release information to