Welcome to the Office of

JOHN C. TRUEB, DDS

JEFFREY J. BECKER, DDS

165 St. Dominics Dr., Suite #100
Manteca, CA 95337

Whom may we thank for referring you to our practice? _____

Name:_____Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Home Phone #:_____

School Attending:_____City:_____

Insurance Information

Father's Name:_____SSN:_____Date of Birth:_____

Father's Employer:_____Work Phone #:_____

Employer Address:_____City:_____State:_____Zip:_____

Present Position:_____How Long_____

Dental Insurance Name:_____Group #_____ID#_____Local #:_____

Insurance Address:_____City:_____State:_____Zip:_____

Mother's Name:_____SSN:_____Date of Birth:_____

Mother's Employer:_____Work Phone #:_____

Employer Address:_____City:_____State:_____Zip:_____

Present Position:_____How Long_____

Dental Insurance Name:_____Group #_____ID#_____Local #:_____

Insurance Address:_____City:_____State:_____Zip:_____

Whom should we contact, outside of your home, in case of emergency?

Name:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Phone: Day:_____Evening:_____

PARENT SIGNATURE:_____DATE:_____

PATIENT RECORD #:_____

JOHN C. TRUEB, DDS
JEFFREY J. BECKER, DDS
165 St. Dominics Dr., Suite #100
Manteca, CA 95337

HEALTH HISTORY

Patient Name:_____Patient Record #:_____

Date of Birth:_____

Physician's Name:_____Phone #:_____

Physician's Address:_____City:_____

1. Are you Allergic to or ever had a Bad Reaction to:

Penicillin	Yes	No	Local Anesthetic	Yes	No
Aspirin	Yes	No	Other Medications	Yes	No
Codeine	Yes	No	*List:*_____		
Latex	Yes	No	_____		
Sulfa	Yes	No			

2. Have you ever had a Heart Attack? Yes No

3. Have you ever had a Angina/Chest Pain? Yes No

4. Have you ever had a Joint Replacement? Yes No

5. Are you/have you taken Bisphosphonate medication? Yes No

6. Do you have or have you ever had or been treated for: (please circle any that apply)

Anemia	Blood Transfusion	Pacemaker	Cancer
Bleeding Tendencies	HIV+ / ARC	Epilepsy/Seizures	Radiation Treatment
High Blood Pressure	AIDS	M.S.	Stroke/CVA/TIA
Diabetes	Hepatitis	Asthma	Psychological Disorders
Thyroid Disease	Cirrhosis	Lung Disease	STD
Kidney Disease	Ulcers	Tuberculosis	Congestive Heart Failure
Glaucoma	Coronary Artery Disease	Sjogren's Syndrome	Osteoporosis

8. Please list any Medications you are taking:

Medicine: _____ *Reason:* _____

_____ _____

_____ _____

9. Women: Are you Pregnant? Yes No

10. Have you been Hospitalized within the last 3 years? Yes No

Reason: _____

12. Have you ever had a Drug or Alcohol Dependency? Yes No

13. Do you consume Alcoholic Beverages? Yes No

14. Do you Smoke or use Tobacco? Yes No

DATE: _____

PATIENT SIGNATURE: _____

DR. SIGNATURE: _____

B.P. _____

Pulse _____

Pre-Med _____ Yes_____No_____

Allergy _____

Med. Complications_____

JOHN C. TRUEB, DDS
JEFFREY J. BECKER, DDS
165 St. Dominics Dr., Suite #100
Manteca, CA 95337

DENTAL HEALTH QUESTIONNAIRE

Last Name First Name Middle Date

Please answer the following important questions to the best of your ability

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious difficulty associated with previous dentistry? Yes No
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
6. How often do you brush? _____
7. Have you ever had orthodontia treatment (braces, Invisalign)? Yes No
8. Are you satisfied with the appearance of your teeth? Yes No
9. Is there anything you would change about your mouth or smile if you could? Yes No
10. If so, what would you want to change?

_____

_____

_____

11. Have you ever had or considered teeth whitening? Yes No
12. Do you have any questions about dentistry and oral health that have not been adequately answered? Yes No
13. Do you have or have you ever had any of the following?

MOUTH			TEETH		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blister, lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Biting cheeks/lips	Yes	No	Food impaction	Yes	No
Clicking/poppling jaw	Yes	No	Clenching/grinding	Yes	No
Difficulty opening or closing jaw	Yes	No	If so, when	Daytime	Night
Ever had a nightguard	Yes	No	Change in bite	Yes	No

14. Do you use the following?

Brush	Yes	No
Fluoride rinse	Yes	No
Dental floss	Yes	No
Other	Yes	No

JOHN C. TRUEB, DDS
JEFFREY J. BECKER, DDS
165 St. Dominics Dr., Suite #100
Manteca, CA 95337

WRITTEN FINANCIAL POLICY

Thank you for choosing our office for your dental needs. Our primary mission is to deliver caring and comprehensive dental treatment. An important part of our mission is making the cost of optimal care easy and manageable for you by offering several payment options.

Payment Options:

- Cash or Check
- Visa, MasterCard, American Express or Discover
- We offer a 5% cash discount to patient who do not have insurance[1]
- Payment plans from CareCredit:
  - Allow you to pay over time with no interest[2]
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

Insurance Plans:

- We will work with your insurance carrier to maximize your benefits and bill them for reimbursement for your treatment[3]
- Co-payments are due at the time treatment is rendered unless other financial arrangements are made

Missed/Canceled Appointments:

- A fee will be charged for missed or canceled appointment without providing a 48-hour notice

A return check fee will be applied on all returned checks

A finance charge of 1.5% will be applied to all balances that are 90 days and older

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Restrctions apply
[2]Subject to credit approval and must be paid within the promotional period
[3]If payment is not received from your insurance carrier within 60 days, you will be responsible for payment in full

{John C. Trueb, DDS}
{Jeffrey J. Becker, DDS}

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/16/03), 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 the 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 of 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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 was 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. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for you healthcare, but only if you agree that we may do so.

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 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

you 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 will not use your health information for marketing communications without your written authorization.

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

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice-mail messages, postcards, or letters).

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 using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 of disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

{John C. Trueb, DDS}
{Jeffrey J. Becker, DDS}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____E-mail:_____

Patient Number:_____Social Security Number:_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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: Dawn_____

Telephone: 209-823-3574_____Fax: 209-239-4378_____

E-mail: _____

Address: 165 St. Dominics Dr., Suite #100, Manteca, CA 95337_____

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.

SIGNATURE

I, _____, 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 health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

{John C. Trueb, DDS}
{Jeffrey J. Becker, DDS}

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this office's Notice of Privacy Practices

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other {Please Specify}

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Authorization for Release Of Confidential Dental Records

I, _____ authorize release of all dental records
(please print name)

including perio charting and x-rays for_____ from:
(print patient's name)

_____
(Name of previous dentist)

_____
(Address)

_____
(City, State, and Zip Code)

_____
(Phone)

TO:

John C. Trueb, DDS
Jeffrey J. Becker, DDS
165 St. Dominic Dr. Suite #100
Manteca, CA 95337
(209) 823-3574

Please e-mail x-rays when possible
E-mail: reception@johnctruebdds.com

_____ _____
Print Patient's Name **Date of Birth**

_____ _____
Patient or Parent Signature **Date**

PATIENT ACKNOWLEDGMENT
OF
RECEIPT OF DENTAL MATERIALS
FACT SHEET UPDATE
AS OF 5/04

"I have received a copy of the Dental Materials Fact Sheet as required by law".

_____ _____

Patient Signature *Date*