THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL) Date______________________

First Name__________________________ Middle Initial ______ Last Name _____________________________
Birth date______________________________ SS #____________________ □ Male □ Female
Check Appropriate Box: □ Minor □ Single □ Married/Partnered □ Separated/Divorced □Widowed

Home Phone___________________________ Cell Phone___________________________
Address____
City______________________________ State_____________ Zip_____________________
Email____
Employer____ Work Phone____________________________
Address____________________________________ City_____________________ State______ Zip__________

Whom May We Thank for Referring You?____
Person to Contact in Case of Emergency_________________________________Phone____________________

RESPONSIBLE PARTY (If Different From Patient)

Person Responsible for this Account______________________________ Relationship to Patient____________
Birth date______________________________
Address____
City______________________________ State_____________ Zip_____________________ Home
Phone______________________ Cell Phone ___________________Work Phone___________________
Is This Person Currently a Patient in Our Office? □Yes □ No

INSURANCE INFORMATION **□ not covered by dental insurance**

*Please present card(s) to front desk

Primary Insurance Company__________________________________ Phone Number_____________________
Name of Insured____ Relationship to Patient_____________
Birthdate______________________ SS#___________________________
Grp#___________________________ Policy ID#______________________

Secondary Insurance Company_______________________________ Phone Number_____________________
Name of Insured____ Relationship to Patient_____________
Birthdate______________________ SS#___________________________
Grp#___________________________ Policy ID#______________________

Patient Name: ___________________________

MEDICAL HISTORY (confidential)

Are you under the care of a physician/or other health care provider? Yes or No
If yes please explain:____
Physician/Health Care Provider Name: _________________________ Phone Number:____________________

Allergies/ Sensitivities *(mark all that apply)*

☐ **NONE**

- ☐ *Local anesthetics*
- ☐ *Aspirin*
- ☐ *Penicillin/ Amoxicillin*
- ☐ *Sulfa drugs*
- ☐ *Codeine or Narcotics*
- ☐ *Latex*
- ☐ *Acrylic*
- ☐ *Metals*
- ☐ *Iodine*
- ☐ *Other:* _________________________

1. Are you or have you ever taken bone density medications (Bisphonates)? Yes or No
If yes, what & when: __________________________

2. Have you ever taken “Fen-phen”? Yes or No

3. Have you ever had a joint/ valve/ bone replacement? Yes or No
If yes, what & when: ____________________________

4. Do you require Antibiotics prior to treatment? Yes or No

Women Only
Are you pregnant? No or Yes & # of weeks: ______
Are you breastfeeding? Yes or No

Please list all diseases and health problems you have or have had:
☐ Asthma ☐ High/low blood pressure ☐ Diabetes
____
____
____
____
____

Please list all medications you currently take: ☐ **NONE**
____
____
____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify office of updates as needed, prior to any treatment.

Signature of Patient/Legal Guardian: ____________________________________**Date:**_________________

Patient Name: ___________________________

Office Policies Consent (Please read carefully and initial consent on each line)
(Page 1)

Privacy Policy (HIPAA)

We strive to maintain your privacy and do not share records without your permission. We reserve the right to make changes to our policies; updated copies are always available for you online or in the office. *Initials*____________

Payment Policy

Pacific Dental Excellence has a general policy that payment is due and payable at the time of treatment. Professional services are charged directly to the patient and the patient is solely and personally responsible for payment.
For your convenience we accept cash, check, all major credit cards, and have outside financing available.

Please Note: the cost of dental treatment, even with insurance, can be in the hundreds or even thousands of dollars. Our office has made arrangements with CareCredit and Lending Club to help you get the treatment you need now with payment plans you can afford. These accounts must be approved prior to treatment. *Initials*___________

Balances over 60 days will incur an interest charge of 2% per month and after 90 days, an additional $10.00 rebilling fee per statement may be charged. Returned checks will have an additional fee of $35.00 added to the amount of the returned check. *Initials*____________

Cancellations/ No Shows

All scheduled appointments will receive a courtesy phone call or text message 72-48 hours prior to your appointment. It is important that our office has current phone numbers and addresses at all times. It is important that our office has current phone numbers and addresses at all times. Ultimately, it is your responsibility to keep track of your appointments that you have scheduled.
Patients who miss their appointment or cancel with less than 48 hours' notice prior to the appointment will be charged at a rate of $200.00 per hour scheduled. Unlike most dental offices, at Pacific Dental Excellence we do not book multiple appointments at the same time. That means your missed appointments could have gone to another patient and our staff could have been providing quality dental care. Thank you for understanding. We understand that sometimes last minute cancellations are unavoidable.
Individual circumstances may be discussed with the office manager and/or the dentist.

*Initials*____________

Refunds and Credits

All refund requests must be submitted in writing to the office for consideration. Any available refunds will be issued within two weeks of the office receiving the request in the form of the original payment. Cash refunds will be issued by check only. Please understand this office will not consider any refunds for completed treatment. If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist. In the event of a refund the patient will be responsible for any of the fees incurred by the office for treatment and/or financing.
In the case of overpayment or changes to treatment causing a credit to an account, we are happy to either refund the patient their paid portion, or leave a credit on the account to be applied towards future treatment.

*Initials*____________

Patient Name: ___________________________

Office Policies Consent (Please read carefully and initial consent on each line)
(Page 2)

Insurance

We are happy to bill both your primary and secondary insurance carriers as a courtesy for our patients. Please understand that you, the patient, is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **Our financial relationship is with you, not your insurance company**.

1. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Services NOT covered by your insurance company are charged with our standard office fees.
2. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due.
3. We will do our best to ESTIMATE insurance coverage and patient portions due. THIS IS JUST AN ESTIMATE NO GUARANTEES ARE MADE REGARDING PAYMENNTS FROM INSURANCE COMPANIES. We will send pre-estimates for services over $300 ONLY at your request, again these are not guarantees. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. *Initials*____________

AUTHORIZATION AND RELEASE

I ____CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE.

THE INFORMATION I PROVIDED IS ACCURATE, 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.

Signature: _____________________________________Date: ________________

Patient Name: ____________________________________

General Consent for Treatment

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 my treatment. I recognize that long term success depends upon my cooperation and routine maintenance. I understand and accept that the consequences if no treatment is administered may include but are not limited to: infection, decay, and the need for additional restorations.

I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a diagnosis of my dental needs. I also authorize the Doctor to provide any and all forms of treatment, medication and therapy that may be indicated as we mutually agree upon them.
I understand that there are substantial risks and consequences that may be associated with any surgical, dental, diagnostic, or anesthetic procedure. I understand that not every conceivable hazard can be listed, but that the following possibilities exist, however infrequent or rare:

> Damage to adjacent teeth or fillings, Post-operative infection, Swelling, bruising or sensitivity, Infection, Allergic reactions to medications, or anesthesia, or Complications during treatment necessitating additional treatment or referral to a specialist.

Unforeseen conditions may arise during the procedure that requires a different procedure than set forth. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are necessary.

I understand that any medications, drugs, anesthetics, and prescriptions taken for my procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs because they can increase these effects. I have been advised not to work and not to operate any vehicle, automobile, or hazardous devices while taking such medications and until fully recovered from their effects.
Patients may require local anesthesia for their comfort during the performance of dental restorations or surgical procedures. Your dentist will recommend and explain to you which type of anesthesia might be appropriate for your individual medical/dental needs.

Female patients: Because anesthetics, medications and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion, every female must inform the dentist if she could be or is pregnant. Anesthetics, medications and drugs absorbed in the mother’s milk may temporarily affect the behavior of the nursing baby. In either case, the anesthesia and treatment may be postponed.

Ozone Therapy: Dental/Medical Ozone Therapy is used in this office to treat conditions that involve bacteria, virus, fungal, and parasite infections. This dental therapy can be applied externally or through injection. As with any injection there are risks of pain, bruising, and blisters at the injection site. Dental Ozone has clinically been observed to increase circulation, oxygenation, and improved immune response in clinical dental application. The use of Ozone has been in the United States since 1885. The FDA has not reviewed or approved statements made regarding the effective use of medical/dental ozone in clinical treatment. Results in treatment may vary and no claims are being made in the specific treatment for any condition for any particular reason.

I acknowledge and understand the above information provided herein is correct and I will give any updates regarding my personal or medical history as needed. I will ask any and all of my questions regarding my treatment, including my alternative forms of treatment, the advantages and disadvantages of each, and have my questions regarding fees answered. I give permission for the doctor to proceed with examinations, x-rays, diagnosis, and treatment as needed.

Patient’s Signature: ____ *Date:* __________________