Evergreen Valley Dental Office

Patient Information

Patient Name: ______ Last, First MI (Preferred Name) ______ Date: ______

Social Security #: ______ Birth Date: ______ Gender: _____ Family Status: ______

Phone (Home): ______ (Work): ______ (Cell): ______

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ TH ☐ F

Address: ______ Street ______ Apartment #

City ______ State ______ Zip Code ______

Health Information

Date of Last Dental Visit: ______ Reason for this Visit: ______

Have you ever had any of the following? Please circle Yes or No:

AIDS - Y or N

Fainting Y or N	Excessive Bleeding Y or N	Nervous Disorders Y or N	Venereal Disease Y or N
Allergies ______	Glaucoma- Y or N	Pacemaker Y or N	Codeine Allergy Y or N
______	Growths- Y or N	Pregnancy Due Date: ______	Penicillin Allergy Y or N
Anemia- Y or N	Hay Fever- Y or N	Radiation Treatment Y or N	Nickel & Cobalt Allergy Y or N
Arthritis- Y or N	Head Injuries- Y or N	Respiratory Problems Y or N	Phen Phen Intake Y or N
Artificial Joints/Valves- Y or N	Heart Disease- Y or N	Rheumatic Fever Y or N	Biphenyl Y or N
Asthma- Y or N	Heart Murmur- Y or N	Rheumatism Y or N	Latex Allergy Y or N
Blood Disease- Y or N	Hepatitis- Y or N	Sinus Problems Y or N	Mental Disorders- Y or N
Cancer- Y or N	High Blood Pressure- Y or N	Stomach Problems Y or N	Ulcers Y or N
Diabetes- Y or N	Jaundice- Y or N	Stroke Y or N	
Dizziness- Y or N	Kidney Disease- Y or N	Tuberculosis Y or N	
Epilepsy- Y or N	Liver Disease- Y or N	Tumors Y or N	

Have you ever had any complications following dental treatment? Yes or No
If yes, please explain: ______

Have you been admitted to a hospital or needed emergency care during the past two years? Yes or No
If yes, please explain: ______

Are you now under the care of a physician? Yes or No
If yes, please explain: ______
Name of Physician: ______ Phone: ______

Are you currently taking any medications? Yes or No
If yes, please explain: ______

The information that I have provided are true and correct to the best of my knowledge. Should there be any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient, Parent, Guardian ______ Dr. Signature ______ Date:

Referral Information

Whom may we thank for referring you to our practice? ☐ Managed Care Insurance ☐ Another Patient ☐ Building Location
☐ Yellow Pages ☐ Newspaper ☐ Insurance Listing ☐ Flyer/Mail sent to you ☐ Other______
Name of person or office referring you to our practice: ______

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ______________________________

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

Evergreen Valley Dental Office

General Dentistry Informed Consent

Patients Name______________________________Date:_______________________

1. **X-Rays & Initial Oral Examination**
   In order to proper diagnose any treatment or evaluate an area in your mouth we would need to take X-rays and do a routine oral examination__________(Initials here)
2. **Drugs, medication, and sedation**
   I have been informed and understand that antibiotics, and other medications can cause an allergic reaction causing swelling of tissue, pain,itching,vomiting,and or anaphylactic shock. I have been advised that taking antibiotic will reduce the effectiveness of any birth control pill. I understand and I am in full agreement not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in this office for my care. I understand that failure to take medications prescribed for me in a manner in which they were prescribed may offer risks of continued or aggravated infection and pain, with potential resistance to effective treatment of my condition.
   (Initials Here_______)
3. **Changes in treatment plan**
   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 apparent during the examination. The most common being root canal therapy following routine restorative procedure. I give my permission to the dentist to make any/all changes and additions necessary. (initials here______)
4. **Amalgam fillings**
   I understand that I will be having an amalgam (silver) filling. I have been informed that amalgam contains mercury and that there are could be some health risks associated with the amalgam. All options have been explained to me in detail including doing nothing.(Initials here___________)
5. **Composite (white) Fillings**
   I have been informed of the risks and the benefits of composite (white) fillings. I understand that the cost is higher and that my insurance company might not cover, all or part of the cost.
   (initials________)
6. I ____________________ acknowledge that I have received from Evergreen Valley Dental Office

   a copy of the dental material fact sheet dated October 2001.

I authorize and understand that each dentist is an individual practitioner and individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment. I acknowledge the receipt of and understand all post –operative instructions.

Patients Signature:____________________________ **Date:**______________

Doctors Signature:________________________ **Witness Signature:**__________________

Evergreen Valley Dental Office
Family & Cosmetic Dentistry

Name____________________ Date________________

I acknowledge full financial responsibility for service rendered by *Evergreen Valley Dental Office.*
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made.

I further authorize and request that insurance payment be made directly to *Evergreen Valley Dental Office* should it elect to receive such payments. Any unpaid balance occurred due to insurance termination will be paid by me.

I have read and fully understand the above consent for financial responsibility and insurance authorization.

Signature:____________________ Name(print)____________________

Date:____________________

Shobha Parikh D.M.D. 4868 San Felipe Rd.,120 San Jose Ca 95135 (408)528-8303 (408)528-8305 Fax

<u>**Evergreen Valley Dental Office**</u>

{NAME OF PRACTICE}

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: **Shobha Parikh, D.M.D.**

Telephone: **(408) 528-8303** Fax: **(408) 528-8305**

E-mail: sparikh@evdentaloffice.com

Address: **4868 San Felipe Rd., Suite#120, San Jose, CA 95135**

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 heath 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: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________________

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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