Plaza Dentistry

16769 Bernardo Center Drive, Suite 17
San Diego, CA 92128
(858) 485-8380

About You

Patient Name:

_____

I prefer to be called:_____

Male / Female

Email Address:

_____

Home Address:

_____

City: _____Zip: _____

Birthdate: _____/_____/_____

SS#:_____-_____-_____

Single / Married / Partnered / Divorced

HM # :(_____) _____

Cell # :(_____) _____

Work # :(_____) _____Ext:_____

DL#: _____

Employer:

_____

Employer's Address:

_____

_____

Who May we Thank for referring you:

_____

Other family members seen by us:

_____

Person Responsible for Account:

_____

Spouse Information

His/ Her Name:

_____

Employer:

_____

Birthdate: _____/_____/_____

SS#:_____-_____-_____

Relative or Friend not living with you

His/ Her Name:_____

Contact #:(_____) _____

Primary Insurance Information

Insurance Co. Name: _____

Insurance Co. Address:

_____

_____

Insurance Co. Phone#: (_____)_____

Group # (Plan, Local, Policy#):_____

Subscriber Name:_____

Subscriber Birthdate:_____/_____/_____

ID: _____

SS#: _____-_____-_____

Secondary Insurance Information

Insurance Co. Name:_____

Insurance Co. Address:

_____

_____

Insurance Co. Phone#: (_____)_____

Group # (Plan, Local, Policy#):_____

Subscriber Name:_____

Subscriber Birthdate:_____/_____/_____

ID: _____

SS#: _____-_____-_____

Payment is due in full at the time of treatment

Unless prior arrangements have been approved

If this office accepts my dental insurance, I understand that I am responsible for payment of services rendered and that I am also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize release of any information, including diagnoses and records of treatment to my insurance company for billing purposes.

_____ _____

Patient/Guardian Signature Date

MEDICAL HISTORY

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 six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart 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 (i.e. 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 (i.e. celiac disease, gastric reflux) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐

	YES	NO
27. arthritis _____	☐	☐
28. autoimmune disease _____	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, 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		
(i.e. 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/development delay, or other treatment that may possibly affect your dental treatment.
(i.e. Botox, Collagen Injections)

_____

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

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Date of last dental visit _____**Name of your previous dentist**_____

Reason for today's visit _____

Have you ever had an oral cancer screening? YES / NO

How often do you floss your teeth?
_____

Do your gums bleed when you brush? YES / NO

Have you or a family member ever been treated for periodontal disease? YES / NO

Have you ever had complications from an extraction? YES / NO

Have you ever had a popping or clicking near your ear when you chew? YES / NO

Are you prone to frequent headaches? YES / NO

Do you grind or clench your teeth? YES / NO

Do you have sores, blisters or swelling on your gums lips or cheeks? YES / NO

Have you ever had orthodontic treatment? YES / NO

Do you snore? YES / NO

Do you have problems with bad breath? YES / NO

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? YES / NO

Have you ever used an electric toothbrush? YES / NO

Are your teeth sensitive to hot, cold or pressure? YES / NO

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

_____

If you could change something about your smile it would be (circle all the apply):

Whiter

Straighter

Replace metal amalgam fillings with tooth colored fillings

Repair chipped teeth

Replace missing teeth

Replace old crowns due to color or shape

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this or my medical history form.

Patient/Guaradian Signature: _____ Date: _____

Our Commitment to You

We would like to take this opportunity to thank you for being an important member of our dental practice and to assure you of our dedication in providing excellent dental care for you and your family. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Appointments

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments.

• Should any scheduling change be required, we request at least 24 hours advance notice to avoid a $75.00 cancellation fee.

Courtesy Reminder Calls

As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment, but please do not depend on this courtesy.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

Initial_____

Insurance

We are pleased that you have dental insurance to help you with partial assistance in your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relation constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines.

Initial_____

Financial Arrangement

Dental treatment is an excellent investment in an individual's medical and psychological well-being. We are available to answer your questions and assist you in any way we can. We happily accept cash, credit cards (VISA/Mastercard/American Express, and Discover). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion copays at the time treatment is provided.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines.

Initial_____

HIPAA

The Health Insurance Portability and Accountability Act of 1996 requires that healthcare professionals give patients a copy of the office notice of privacy practice and make good faith effort to obtain and acknowledgement of the receipt of same.

Continued on next page

By initialing this section and signing below, you indicate that you have been offered a copy of the office notice of privacy practices.

Initial_____

Dental Materials Fact Sheet

Law requires that dental professionals give patients a copy of the Dental Materials Fact Sheet dated May 2004 prior to having restorative work performed and make good faith effort to obtain and acknowledgement of the receipt of same.

By initialing this section and signing below, you indicate that you have been offered a hard copy of the Dental Materials Fact Sheet dated May 2004 by Plaza Dentistry, and have been given the opportunity to review this document prior to having restorative work performed. Your initial also indicates that you have been informed that you can access this document online at:

https://www.dbc.ca.gov/formspubs/pub_dmfs_english_webview.pdf.

Initial_____

Medical History Information

Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or other medications. Please be sure to provide us with a list of any drug allergies you have.

By initialing this section and signing below, you indicate that you understand and agree to these medical history information guidelines.

Initial_____

Changes in Treatment

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, for example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary after consultation.

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding possible changes in treatment.

Initial_____

Complications

Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). [It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe.] [Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding possible complications related to dental treatment.

Initial_____

Dental X-Rays and Photos

Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

By initialing this section and signing below, you indicate that you understand and agree to these dental x-ray and photo guidelines.

Initial_____

Specific Problem Examination

In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding focused evaluations.

Initial_____

Minors

We must receive written consent prior to performing any non-emergency dental procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures, unless they have been given written consent by the parent or legal guardian. Please do not send your child to an appointment alone or with someone other than yourself, unless you have filled out any necessary consent forms prior to the appointment, otherwise we may have no choice but to reschedule your child's appointment to another day.

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding treatment of minors.

Initial_____

Security Cameras

Plaza Dentistry has an on-premise security monitoring system to ensure the safety and security of our staff, patients, and assets. There are visible security cameras positioned throughout the office, but only in areas where there is no expectation of privacy. In privacy-protected areas (i.e. bathrooms), there is NO surveillance being conducted. The footage is for internal use only, and is not shared with any external or third-party entities unless in conjunction with a legal matter or crime, and/or with the expressed consent of all parties involved (in cases where such consent is legally required).

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding Plaza Dentistry's surveillance measures.

Initial_____

Specialty Referral

General dentists perform most of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist, but will assist you with said referral should such a situation arise.

Continued on next page

By initialing this section and signing below, you indicate that you understand and agree to these guidelines regarding specialty referrals.

Initial_____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions. I consent to allow Plaza Dentistry to take x-rays and perform an examination on me today.

We appreciate your understanding in our efforts to provide you with a positive experience.

_____ _____

Patient/Guardian Signature Date

Notice of Privacy Practice
HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified to your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. Additional information is available by calling the U.S Department of Health and Human Services or online at: www.hhs.gov

For this reason, our practice has adopted the following policies:

I. Patient information will be kept confidential except as is necessary to provide treatment to ensure that all administrative matters related to your care are handled appropriately. This specifically included the sharing of information with other healthcare providers, laboratories, as is necessary and appropriate for your care. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, ect. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

II. It is policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

III. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentially rules of HIPAA.

IV. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

V. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or Office Manager.

VI. Your confidential information will not be used for purposed of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods or nominal value.

VII. The practice agrees to provide the patient with access to their records in accordance with state law.

VIII. The practice may change, add, delete or modify any of these provisions to better service the needs of both the practice and the patient.

IX. You have the right to request restriction in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, the practice is under no obligation to alter internal policies to conform to your request.

X. There is no patient right to litigation under HIPAA

-Patient Copy-