WELCOME

Patient Information

Date

SS/HIC/Patient ID #

Patient Name

Last Name

First Name | Middle Initial

Address

E-mail

City

State | Zip

Sex ☐ M ☐ F Birthdate | Age

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School

Occupation

Employer/School Address

Employer/School Phone ( )

Spouse's Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

Dental Insurance

Who is responsible for this account?

Relationship to Patient

Insurance Co.

Id #

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name

Birthdate | SS#

Relationship to Patient

Insurance Co.

Group #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date | Relationship to Patient

Phone Numbers

Phone (_____) | Work (_____) | Ext | Alt.Phone (_____)

Spouse's Work (_____) | Best time and place to reAlt.you

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name | Relationship

Phone (_____) | Work Phone (_____)

Dental History

Reason for today's visit

Former Dentist

City/State

Date of last dental visit

Date of last dental X-rays

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Address _____

Phone (____) _____

Allergies

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Avah Dental Office
1001 W San Marcos Blvd Ste 106C
San Marcos CA 92078 760.539.7195

NOTICE OF PRIVACY PRACTICES

Acknowlegment of Receipt

By signing this form, you acknowlegde receipt of the "*NOTICE OF PRIVACY PRACTICES*" provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our "*Notice of Privacy Practices*" is subject to change. If we change out notice, you may obtain a copy of the revised notice by accessing our website, contacting the Privacy Office, or at the Clinic.

I acknowledge receipt of the "*NOTICE OF PRIVACY PRACTICES*"
Patients Name:_____
DOB:
Medical Record #:_____
Signature: _____
Date Signed: _____
If signed by someone other than patient, indicate relationship:
_____
Name of Legal Representative:
_____

Avah Dental Dental Financial Policy & Consent for Services

Welcome to our office. We are dedicated to providing you with the very best dental care and services, as a result, your understanding of our financial policy is an essential element of your care and treatment. To assist you, we have the following financial policy. Please read it thoroughly. If you have any questions, please feel free to discuss them with our office staff.

-Dental Insurance Policy- Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. We are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. You, the financially responsible party, agree that should your insurance company fail to pay any portion of the claim(s) due to frequency limitations, exclusions, maximums, deductibles, age limitations, waiting periods, eligibility, termination or any other reason not listed you are 100% financially responsible for all fees not covered or paid by your plan. Benefits and eligibility are verified upon request from the patient. It is patient responsibility to provide us with accurate insurance benefit details including a copy of the insurance card if applicable, subscriber ID, birthdates, and any other information pertaining to acquiring insurance benefits. Insurance carriers only provide a Summary of dental benefits and not a guarantee of payment. This office cannot render services on the assumption that our charges will be paid by your dental insurance. If something is not covered on your insurance plan, it does not mean it was not necessary, it simply means it may NOT be a covered benefit on your particular dental plan. For benefit details about your plan please call your dental insurance company directly for the most accurate information. I understand that Dental Insurance carriers cannot and do not diagnose treatment. The goal of dental insurance is to pay for the least expensive option for dental treatment not the best option for your health. Insurance carriers may downgrade their payments for procedures. Pre-Authorizations are NOT a guarantee of payment. Patient is responsible for any non-covered benefits regardless of estimates provided.

-Payment/Patient Portion is due when services are rendered unless a prior payment arrangement has been made: For your convenience, we accept Visa, MasterCard, Discover, and American Express credit cards; we also accept cash and check payments. Outside financing is available through Care Credit with interest free payment options (6 mo. for under $1000, and 12 mo. for over $1000 (Care credit cannot be combined with Promotional offers).

-Deposit Policy- Due to the extensive amount of time our staff and doctors devote to preparing for your appointment We do require a deposit to reserve your time with the doctor for major dental work. In the event you cancel, reschedule or no show with less than 2 business days' notice, you will forfeit your deposit and be required to pay a new deposit upon rescheduling

-Reschedule/ Change in Schedule Policy- Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours-notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50.00 will be charged for every hour of allotted time cancelled

-In the event your account balance is 30 days past due, a $20 per month late fee will be charged to your account and will be sent to collections after 90 days. A $50 fee for cancelled/returned checks will also be added to your account.

-There is a fee to copy/e-mail patient records, unless we are copying them for a specialist referral we have arranged. They require a release form signed and may take 5-10 business days to process. - free consultations/exams x-ray duplication is $110

-Minors- Separated or divorced parents of minors, who are responsible for one half of the cost of a child/children dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file.

COVID-19- While our office complies with the State Health Department and CDC infection control guidelines to prevent the spread of the Covid-19 virus, we cannot make any guarantees. Our staff are symptom free, and to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (incl other patients) could be infected with, or without their knowledge. I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

Consent for Services & Standard of Care

Standard of care is a legal concept that a dentist must meet and is the basic practices of highly regarded dentists who have comparable education and knowledge, who practice in similar disciplines and those who practice in a comparable area. The standard simply reflects that which is minimally required, meaning that anything less would be considered negligent.

Standard of care for our office is as follows: PPE fee may be added to your appointment

The doctor and hygienist recommend regular cleanings a minimum of 1 time every 6 months, regardless of insurance coverage. The type of cleaning is determined by the health of your teeth and gums not by your insurance.

Fluoride Varnish to protect my teeth from cavities- min. 2 times a year and may not be covered by insurance

Periodontal maintenance cleanings 1 time every 3-4 months with irrigation which may not be covered by insurance

Doctor/Dentist requires x-rays be taken in order to be able to diagnose accurately.

Dental X-rays are a very important diagnostic tool- We require at a minimum Full mouth x-rays are taken every 3 years, check-up x-rays are taken annually. We will accept digital x-rays from another office as long as they are less than 3 mo. Old from the date taken Emergency/ Limited Exam/Dental Treatment x-rays are taken as needed.

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor. I give consent to the doctor or designated staffs use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for purpose of carrying out my treatment, payment and health care operations to make a thorough diagnosis of myself or my dependents dental needs. I grant my permission to you or your assignee, to telephone, text, e-mail me at home or at my work to discuss matters related to my dental health as well as to receive appointment reminders and confirmations. I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized.

I, (please print) _____, have read and understand the Consent for Services for NCFD

Signed patient/parent/guardian: _____ Date: _____