Concord Dental Arts
2222 East St., Suite 270, Concord, CA 94520
(925) 689-3500

Parent Name (for minors): _____ Email:

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ CDL: _____ Birth Date:_____

Phone (Home): _____ (Cell): _____(Work)_____

Address: _____
Street Address

_____
City State Zip Code

Employer Name/ Phone Number: _____
Name Phone number

Address: _____
Street Address City State Zip Code

Dental Insurance Information: _____
Insurance company name

Dental History

Date of Last Dental Visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

Did any previous dentist recommend dental treatment that was never performed? ☐ Yes ☐ No
If yes, what type of work was it? _____

Why wasn't this treatment ever performed?
_____

Do you feel nervous about dental treatment? ☐ Yes ☐ No

Have you ever had a negative dental experience? ☐ Yes ☐ No
If so, please describe_____

How often do you have dental exams? _____How often do you brush? _____

How often do you floss? _____

Have you ever had?

Orthodontic treatment? _____ ☐Yes ☐No
Oral surgery? _____ ☐Yes ☐No
Periodontal treatment? _____ ☐Yes ☐No
Your teeth ground or bite adjusted? _____ ☐Yes ☐No
A bite plate or mouth guard? _____ ☐Yes ☐No
A serious injury to the mouth or head? _____ ☐Yes ☐No

Have you experience?

Clicking or popping of the jaw? _____ ☐Yes ☐No
Pain (joint, ear, side of face)? _____ ☐Yes ☐No
Difficulty in opening or closing the mouth? _____ ☐Yes ☐No
Difficulty chewing on either side of the mouth? _____ ☐Yes ☐No

Are your teeth sensitive to?

Hot or cold? _____ ☐Yes ☐No
Sweets? _____ ☐Yes ☐No
Biting or chewing?_____ ☐Yes ☐No
Mouth odor or bad tastes? _____ ☐Yes ☐No
Do you get cold sores, blisters, or other oral lesions? ☐Yes ☐No
Do your gums bleed or hurt? _____ ☐Yes ☐No
Have your parents had gum disease or tooth loss?_____ ☐Yes ☐No
Notice any loose teeth or change in your bite? _____ ☐Yes ☐No
Does your food tend to become caught between any teeth? ☐Yes ☐No

Do You?

Clench/grind teeth while awake or asleep? _____ ☐Yes ☐No
Bite your lips or cheeks regularly? _____ ☐Yes ☐No
Mouth breathe while awake or asleep? _____ ☐Yes ☐No
Have tired jaws, especially in the morning? _____ ☐Yes ☐No
Smoke/chew tobacco? _____ ☐Yes ☐No
Sore muscles (neck, shoulders)? _____ ☐Yes ☐No

_____ Date:_____

Signature of patient, parent or guardian

Whom may we thank for referring you to our practice?

☐Friend ☐ Relative ☐ Dental Office ☐ School ☐ Work ☐Other_____

Name of person or office referring you to our practice:_____

Medical History

Please indicate which of the following you have had or have at present:

1. Tuberculosis ☐ Yes ☐ No
2. Asthma ☐ Yes ☐ No
3. Hay fever ☐ Yes ☐ No
4. Latex sensitivity ☐ Yes ☐ No
5. Allergies/Hives ☐ Yes ☐ No
6. Sinus trouble ☐ Yes ☐ No
7. Heart (surgery/disease/attack) ☐ Yes ☐ No
8. Heart disease ☐ Yes ☐ No
9. Heart murmur ☐ Yes ☐ No
10. High blood pressure ☐ Yes ☐ No
11. Mitral valve prolapsed ☐ Yes ☐ No
12. Heart pacemaker ☐ Yes ☐ No
13. Rheumatic fever ☐ Yes ☐ No
14. Arthritis/Rheumatism ☐ Yes ☐ No
15. Stroke ☐ Yes ☐ No
16. Kidney trouble ☐ Yes ☐ No
17. Thyroid problems ☐ Yes ☐ No
18. Ulcers ☐ Yes ☐ No
19. Diabetes ☐ Yes ☐ No
20. Glaucoma ☐ Yes ☐ No
21. JointReplacement ☐ Yes ☐ No
22. Emphysema ☐ Yes ☐ No
23. Chronic Cough ☐ Yes ☐ No
24. Radiation therapy ☐ Yes ☐ No
25. Chemotherapy ☐ Yes ☐ No
26. Tumors ☐ Yes ☐ No
27. Hepatitis A (infectious) ☐ Yes ☐ No
28. Hepatitis B (serum) ☐ Yes ☐ No
29. AIDS ☐ Yes ☐ No
30. HIV positive ☐ Yes ☐ No
31. Cold sores/Fever blisters ☐ Yes ☐ No
32. Blood transfusion ☐ Yes ☐ No
33. Hemophilia ☐ Yes ☐ No
34. Sickle cell disease ☐ Yes ☐ No
35. Bruise easily ☐ Yes ☐ No
36. Liver disease ☐ Yes ☐ No
37. Jaundice ☐ Yes ☐ No
38. Taken Fosamax ☐ Yes ☐ No
39. Epilepsy or seizures ☐ Yes ☐ No
40. Fainting or dizzy spells ☐ Yes ☐ No
41. Nervous/Anxious ☐ Yes ☐ No
42. Psychiatric Psychological care) ☐ Yes ☐ No

Please Answer Following Questions:

Have you been under the care of a medical doctor during the past two years? □Yes □No

If yes, for what _____

Physician's name _____Phone _____

Have you been a patient in the hospital during the past 5 years? □Yes □No
Have you or do you have any disease condition, or problem not listed above? □Yes □No

If yes, please list: _____

Have you taken any medication /drugs during the past 2 years? □Yes □ No
List any medication you are taking and the correlating diagnosis:

_____

Please **check** all medications that you are allergic to.

□ Aspirin	□ Local Anesthetic	□ Penicillin
□ Sulfa	□ Iodine	□ Codeine
□ Latex	□ Barbiturates (sleeping pills)	□ NO ALLERGIES

□ Other (please specify): _____

In Case Of Emergency:
Who Should We Contact?_____
Name Phone Number

Women Only:

Are you pregnant? □Yes ____Months □No
Nursing? □Yes □No
Taking birth control? □Yes □No

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Concord Dental Arts of any change in my health or medications.

Patient/Guardian Signature _____ Date _____

Financially Responsible Person's Information(Not your Insurance Company)

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

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.

Patients who carry dental insurance must understand that as a courtesy to you our office will bill your dental insurance for their estimated portion. Patients are responsible for keeping us informed of your dental plan changes. Patients are responsible for understanding how your dental plan works and pays out towards procedures. Patients are responsible for all balances not paid by your dental insurance.

I understand that the fee estimate listed for my dental care can only be extended for a period of six months from the date the treatment estimate is presented.

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: _____

Signature of the doctor

Concord Dental Arts

Financial Policy

In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer these options for payments:

(1) Visa, MasterCard, American Express

(2) A monthly payment plan based upon credit approval. No courtesy discounts can be applied.

We will as a courtesy, process your insurance claims in our office.

The patient is fully responsible for the total payment of all procedures performed in this office. All services are due to be paid in full as services are provided, regardless of whether or not insurance benefits have been received. One and a half percent (1.5%) per month interest will be charged on account balances 60 days from treatment date.

For appointments of 2 hours in duration or longer, a non refundable deposit will be required in order to reserve the appointment. This deposit will be applied to the total charge of the services rendered.

A minimum of 48 business hours' notice is required for the cancellation/rescheduling of any appointment. For broken or cancelled appointments that are not made within 48 business hours, the deposit will not be applied to services, and an additional deposit may be required in order to reschedule.

For broken appointments, including No-Shows or cancelled appointments of normal duration that are not made a minimum of 48 business hours in advance, a $50.00 per hour fee will be charged for appointments with the hygienist and a $100 per hour fee will be charged for appointments with the treating Dentist. Showing up 20minutes or more late to a scheduled hygiene appointment will be charged as a No-Show.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience at Concord Dental Arts.

It is your responsibility to know which offices and/ or doctors are covered under your particular insurance plan and what benefits, waiting periods, material down grades, etc. are included in that coverage. As a courtesy to you our office will bill your insurance company (if applicable). This practice will try to anticipate all cost up front for dental treatment, so you may plan your financial obligations.

Thank you. The entire team at Concord Dental Arts.

I have read and understood the above conditions and agree to their content.

Signature_____**Date**_____

Patient-Dentist Arbitration Agreement

Article I.6

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered would be determined by submission to arbitration as provided by California Law and not by a lawsuit, or resort to court process, except as California Law provides for judicial review or arbitration proceedings. Both parties of this contract by entering into it, have given up this constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article II.

A. Parties to the Agreement: The term "Patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the forgoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

B. Treatment Covered: patient understands and agrees that any dispute of the sort described in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Other Providers (if Applicable): Patient understands that he or she may at times receive treatment from one or more providers who take call for or otherwise practice jointly with the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article I between Patient and other providers will be subject to compulsory, binding arbitration.

D. Coverage of Pre-Natal Claims (If Applicable): Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes: In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running statute of limitations for 90 days.

B. Method of Initiating Arbitration: If the dispute is not resolved by mutual agreement. Patient may initiate arbitration by notifying Provider to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Provider will designate an arbitrator to act on Provider's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Provider shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

C. Applicable Law: The arbitrator shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if a dispute or pending before a Superior Court of the State of California.

Article IV.

A. Revocation: If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within 30 days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising from dental services prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP THE RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

Patient's Name *(Please print)*: _____

Date: _____ **Signature**: _____

Provider's Name *(Please Print)*: **CONCORD DENTAL ARTS**

Dated: _____ **Signed**: _____

Concord Dental Arts

2222 East Street, Suite 270, Concord CA 94520

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____ **(Print *Patient's name* ***or*** *Parent/Guardian of minor*)**, have received a copy of Concord Dental Art's Notice of Privacy Practices.

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other: (Please specify)

Concord Dental Arts

2222 East Street, Suite 270, Concord CA 94520

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 April 1, 2003, and it 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 or 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 such as: 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 your 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 your 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 health information required for lawful intelligence, counterintelligence, and other national security activities to authorized federal officials. We may disclose to correctional institutions 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 voicemail 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time).

Restrictions:
You have the right to request that we place additional restrictions on our use or disclosure of your 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us via email at concorddentalarts@gmail.com or by phone at (925) 689-3500.

PATIENT COPY-PLEASE KEEP FOR YOUR RECORDS

Concord Dental Arts

Financial Policy

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Thank You, Concord Dental Arts Team.

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