_____

First Name M.I. Last Name Preferred Name [if different]

◯ Male ◯ Female ◯ Single ◯ Married ◯ Other ◯ Child – Responsible Guardian: _____

Date of Birth: ____ ____ / ____ ____ / ____ ____ ____ ____ Social Security #: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Address: _____
Street

_____
City State Zip

Phone #s: (____ ____ ____) ____ ____ ____ - ____ _____ _____ _____ [Home]

(____ ____ ____) ____ ____ ____ - ____ _____ _____ _____ [Cell]

(____ ____ ____) ____ ____ ____ - ____ _____ _____ _____ [Work] Extension: _____

E-Mail Address: _____ Driver's License Number: _____

EMERGENCY CONTACT

_____

First Name M.I. Last Name Relationship to Patient

Phone #: (____ ____ ____) ____ ____ ____ - ____ _____ _____ _____ Extension: _____

PRIMARY DENTAL INSURANCE INFORMATION

_____

Subscriber's Full Name

Date of Birth: ____ ____ / ____ ____ / ____ ____ ____ ____ Social Security #: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Employer: _____ Insurance Company: _____

REFERRAL INFORMATION

☑ Please check as many as apply

◯ Another person/patient: (Please let us know who: _____) ◯ Went to Website ◯ Facebook/Twitter
◯ Dental Insurance List ◯ Received Postcard/Flyer ◯ Groupon ◯ Yellow Pages ◯ Yelp ◯ Building/Location

MEDICAL HISTORY

Please list **any** medications you are currently taking: _____
PLEASE PRINT CLEARLY _____

Are you under a physician's care? ◯ Yes ◯ No If yes, please explain: _____
Have you been hospitalized/had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Do you use tobacco products or e-cigarettes? ◯ Yes ◯ No _____
Do you use any controlled substances? ◯ Yes ◯ No _____
Have you taken or are you taking Bisphosphonates (i.e. Boniva)? ◯ Yes ◯ No

Women, are you: Pregnant/Trying to get pregnant? ◯ Yes ◯ No On any form of contraceptive? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to: ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics
◯ Other known allergies, please list: _____

Please check the circle to answer yes or no that you currently have, or have ever had:

Y N	Y N	Y N	Y N
◯◯ Acid Reflux	◯◯ Convulsions	◯◯ Heart Trouble/Disease	◯◯ Radiation Treatment
◯◯ AIDS/HIV	◯◯ Cortisone Medicine	◯◯ Hemophilia	◯◯ Rapid Weight Loss/Gain
◯◯ Alzheimer's Disease	◯◯ Diabetes	◯◯ Hepatitis A	◯◯ Renal Dialysis
◯◯ Anaphylaxis	◯◯ Drug Addiction	◯◯ Hepatitis B or C	◯◯ Rheumatic or Scarlet Fever
◯◯ Anemia	◯◯ Easily Winded	◯◯ Herpes	◯◯ Rheumatism
◯◯ Angina	◯◯ Emphysema	◯◯ High Blood Pressure	◯◯ Shingles
◯◯ Arthritis/Gout	◯◯ Epilepsy or Seizures	◯◯ Hives or Rash	◯◯ Sickle Cell Disease
◯◯ Artificial Heart Valve	◯◯ Excessive Bleeding	◯◯ Human Papilloma Virus	◯◯ Sinus Trouble
◯◯ Artificial Joint(s)	◯◯ Excessive Thirst	◯◯ Hypoglycemia	◯◯ Spine Bifida
◯◯ Asthma	◯◯ Fainting Spells/Dizziness	◯◯ Irregular Heartbeat	◯◯ Stomach/Intestinal Disease
◯◯ Back Problems	◯◯ Frequent Cough	◯◯ Kidney Problems	◯◯ Stroke
◯◯ Blood Disease/Transfusion	◯◯ Frequent Diarrhea	◯◯ Leukemia	◯◯ Swelling of Limbs
◯◯ Breathing Problem	◯◯ Frequent Headaches	◯◯ Liver Disease	◯◯ Thyroid Disease
◯◯ Bruise Easily	◯◯ Genital Herpes	◯◯ Low Blood Pressure	◯◯ Tonsillitis
◯◯ Cancer	◯◯ Glaucoma	◯◯ Lung Disease	◯◯ Tuberculosis
◯◯ Chemotherapy	◯◯ Hay Fever	◯◯ Mitral Valve Prolapse	◯◯ Tumors or Growths
◯◯ Chest Pains	◯◯ Heart Attack/Failure	◯◯ Osteoporosis	◯◯ Ulcers
◯◯ Cold Sores/Fever Blisters	◯◯ Heart Murmur	◯◯ Pain in Jaw Joints	◯◯ Venereal Disease
◯◯ Congenital Heart Disorder	◯◯ Heart Pace Maker	◯◯ Psychiatric Care	◯◯ Yellow Jaundice

Please rank these IN THE ORDER that would KEEP YOU FROM completing any needed/wanted dental treatment.
(4 being the most worrisome and 1 being the least worrisome)

_____ Fear of pain/dentist _____ Lack of concern _____ Cost of treatment _____ Missing work time

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental exam/xrays: _____

Are you having any dental problems now? ◯ Yes ◯ No If yes, please explain: _____
Are any of your teeth sensitive to: ◯ Hot ◯ Cold ◯ Sweets ◯ Biting/Chewing …or are they ◯ Not Sensitive
Do you regularly use dental floss: ◯ Daily ◯ Weekly ◯ Monthly ◯ Never

Please check all that you currently have or have had in the past:	**Please check if you currently:**
◯ Orthodontic Treatment (braces)	◯ Notice your gums bleed, feel irritated or tender
◯ Oral Surgery (tooth extractions)	◯ Dislike the appearance or color of your teeth
◯ Periodontal (gum) Treatment	◯ Clench or grind your teeth while awake or asleep
◯ Your teeth contoured or your bite adjusted	◯ Bite your lips or cheek regularly
◯ A bite plate or mouth guard	◯ Chew on foreign objects (pencils, pens, fingernails, etc.)
◯ A serious injury to your mouth	◯ Mouth breathe while you are awake or asleep
◯ Unpleasant mouth odors or a bad taste	◯ Have a tired jaw, especially in the morning
◯ Frequent cold sores, blisters or other oral lesions	◯ Experience clicking/popping of the jaw
◯ Places where food gets caught between teeth	◯ Have difficulty opening or closing your mouth
◯ A strong gag reflex	◯ Have difficulty chewing on either side of your mouth

Health Insurance Portability and Accountability Act [HIPAA]

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT INFORMATION/CONSENT

Name:	
Address:	
Telephone:	
E-Mail:	SSN:

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, healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice is on display in the reception room, with copies to take also available. 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 Note 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:

Amber Eddy Phone: (805) 278-8999 Fax: (805) 983-7952
frontdesk@thedentist4u.com 750 W Gonzales Rd. Suite 200 Oxnard, CA 93036

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 we may decline to treat you or continue to treat 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 health care operations.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT UPON REQUEST.

OFFICE USE ONLY

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices.
If there is no signature above, we attest that acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other - please specify:

CONSENT FOR SERVICES

We are very happy to have you as a patient. At our office, we take a lot of pride in meeting or exceeding our patients' needs. This keeps us busy, so we do require each patient to read and understand the following procedures that we follow.

DENTAL INSURANCE

Patients who carry dental insurance assign Drs. Stein/Reitz to file dental claims and accept payment from their insurance company. By signing this consent, they authorize the use of their signature on all insurance submissions. They attest that Drs. Stein/Reitz may use their, and/or their dependents health care information and may disclose such information to their 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. In addition, patients who carry dental insurance are to understand that all treatment proposals are presented with an estimate of what insurance will cover, not a guarantee. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. This office will file most insurance forms and assist in making collections from insurance companies as a courtesy. Any such collections will then be credited to the patient's account and if there is a remaining balance, it is the responsibility of the patient.

FINANCIAL AGREEMENT

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. Account balances aging over 90 days without payment or other financial arrangement are subject to being turned over to a local collections service. If collections proceedings are necessary, it will be at the responsibility of the patient to pay any fees incurred to collect such monies. You also understand that the treatment plan costs listed for this dental care can only be extended for a period of 30 days from the date of the examination.

As a condition of your treatment by this office, financial arrangements must be made in advance for any treatment to reserve the doctor's time. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment is provided. All same-day, emergency or any other dental services performed without previous financial arrangements, must be paid for before these services are performed.

Again, because we want to best serve our patients, we adhere to a strict policy regarding no-show and cancelled appointments. If at least two business days are not given to change or cancel an existing appointment, we reserve the right to charge a broken appointment fee. We are sure you understand that when you miss appointment time reserved specifically for you, other patients in need of treatment cannot be seen. Notice of hospitalization, physician visit or recent death of family waives fee. In addition, if we are unable to make contact to confirm your appointment within four weeks of your scheduled appointment, we reserves the right to double-book your appointment time.

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. 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 were instituted hereunder.

MINOR CONSENT

If you are the parent/legal guardian of the patient listed in this paperwork, you attest that there are no court orders now in effect that prohibit you from signing this consent. You hereby request and authorize the dental staff to perform necessary dental services for the child named, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

I grant my permission to you or your assignee to telephone, text and/or e-mail me to discuss matters related to this form, appointments and/or account balance. I grant my permission for this office to take video/photographs to be used for diagnostic, insurance and practice development purposes (not advertising/social media). To the best of my knowledge, all of the information provided is true and correct. If I ever require a change, I will inform the doctor without fail. I have read the above policies, conditions of treatment and payment guidelines and agree to abide by them.

_____	_____	_____
Signature of patient, parent or guardian	Date	Relationship to Patient