

**NEW PATIENT WELCOME LETTER**

702 Porter Ave Ste F, Stockton, CA 95207

To Our Patients,

We would like to take this opportunity to welcome you to our dental practice. I hope our relationship will be long and happy. To eliminate any possibility of a misunderstanding, we like you to understand your dental insurance policy.

Dental insurance policies are difficult to understand. My staff and I are more than happy to help you understand your dental insurance benefits. As you know dental insurance is designed to aid in paying yearly dental costs. They often do not eliminate it. The schedule of benefits set up by your insurance company is merely a statement of what your plan will pay. Such schedules are not intended to resemble the dentists' actual fees. As a courtesy, we can process your dental claims for you. However, any complaints regarding your dental coverage should be directed to your employer and insurance company.

We are here to provide the best possible dental care; however, we have no say in determining what benefits will and will not be paid by your plan. We are more than happy to give you an estimate, but because of the many exclusions and restrictions in most dental insurance plans, we can not be held liable for any discrepancies. The following is a list of terms insurance companies use. I hope this will help you understand your dental insurance benefits.

I have read the explanation above and fully understand that I will be responsible for any discrepancies between insurance benefits and the cost of dental treatment.

\_\_\_\_\_  
PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STAFF INITIALS

# PATIENT MEDICAL HISTORY

\_\_\_\_\_  
 PHYSICIAN'S NAME: PHYSICIAN'S OFFICE PHONE

\_\_\_\_\_  
 LAST CONSULTATION DATE REASON FOR CONSULTATION

\_\_\_\_\_  
 NAME OF EMERGENCY CONTACT RELATIONSHIP PHONE

What is your current health status? Excellent  Good  Fair  Poor

1. Are you currently under medical treatments? ..... Yes  No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years ..... Yes  No
3. Are you taking any medication(s) including non-prescription medication(s) and bisphosphonate medication(s)? ..... Yes  No   
 If Yes, what medications (please list) \_\_\_\_\_
4. Do you need to pre-medicated with Antibiotics prior to dental treatment? ..... Yes  No
5. Are you currently taking any Blood Thinning medication(s)? ..... Yes  No
6. Do you use any Controlled Substances? ..... Yes  No
7. Do you use tobacco? ..... Yes  No
8. Have you experienced any unfavorable reaction to previous dental treatment? ..... Yes  No

**9. FOR WOMEN ONLY:**

- (A) Are you Pregnant or think you may be Pregnant? ..... Yes  No
- (B) Are you Nursing? ..... Yes  No
- (C) Are you taking Oral Contraceptives? ..... Yes  No

10. Do you have, or have you had any of the following medical conditions? (Please circle mark Yes, or No)

High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Replacement	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	STD	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cardiac Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hay Fever Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Medical Concerns	Yes <input type="checkbox"/> No <input type="checkbox"/>
Use of Bisphosphonates	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any Prosthetic Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Use of Phen-Fen	Yes <input type="checkbox"/> No <input type="checkbox"/>				

11. Please list any allergies the Dentist and staff should be aware of. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## PATIENT HISTORY & INFORMATION

### PATIENT INFORMATION

PATIENT FULL NAME			DATE OF BIRTH (DOB)	AGE	SEX (M/F)
ADDRESS	STREET	CITY	STATE/ZIP	PHONE	
EMPLOYER		OCCUPATION		SOCIAL SECURITY NUMBER	
NAME OF EMERGENCY CONTACT			RELATIONSHIP	PHONE	

### DENTAL INSURANCE INFORMATION

NAME AS IT APPEARS ON INSURANCE			HOW DID YOU HEAR ABOUT OUR OFFICE?		
GROUP/INDIVIDUAL NUMBER			EMAIL ADDRESS		
SUBSCRIBER ID			SOCIAL SECURITY NUMBER		
EMPLOYER		OCCUPATION		SOCIAL SECURITY NUMBER	

### PERSON RESPONSIBLE FOR PAYMENT

FULL NAME			DATE OF BIRTH (DOB)	AGE	SEX (M/F)
ADDRESS	STREET	CITY	STATE/ZIP	PHONE	
EMPLOYER		OCCUPATION		SOCIAL SECURITY NUMBER	

### DENTAL HISTORY

NAME OF FORMER DENTIST			DATE OF LAST EXAM	TREATMENT	
ADDRESS	STREET	CITY	STATE/ZIP	PHONE	

### REASON FOR VISIT

<p><b>GUM</b></p> <p>Have you ever had treatments for gum disease? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do your gums bleed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you had any gum boils or swellings? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>TEETH</b></p> <p>Do your teeth feel loose? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you clench or grind your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you have sensitive teeth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you have pain elsewhere in your face or jaw? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do your teeth come together evenly? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you ever had your teeth straightened? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If Yes, when? _____</p>	<p><b>ORAL HYGIENE</b></p> <p>Are you self-conscious about your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has a dentist shown you how to clean your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>How often do you brush your teeth? _____</p> <p>When was your last cleaning? _____</p> <p>List any dental aids (e.g. mouth guard) _____</p> <p>Is there anything our team should know about your teeth? _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, \_\_\_\_\_ acknowledge that I have received from **Stockton Dental Studio**  
PATIENT NAME DENTIST OR DENTAL OFFICE NAME  
A copy of the Dental Materials Fact Sheet dated October 2001.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA website does not constitute and endorsement of the content of this document.

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## The Dental Board of California Dental Materials Fact Sheet

*Adopted by the Board on October 17, 2001*

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

## HIPPA DISCLOSURE

### HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

#### Stockton Dental Studio

#### Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (\$164.508(a))

I, \_\_\_\_\_ (PATIENT'S NAME) understand that as part of my health care, Stockton Dental Studio, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Stockton Dental Studio notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

### PRIVACY RULE OF PATIENT CONSENT AGREEMENT

#### Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (\$164.506(a))

I understand that:

- I have the right to review Stockton Dental Studio Notice of Information practices prior to signing this consent.
- That Stockton Dental Studio, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Stockton Dental Studio is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Stockton Dental Studio, has already taken action in reliance thereon.

\_\_\_\_\_  
PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

\_\_\_\_\_  
DATE

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization for use/or disclosure of Protected Health Information.

I, hereby authorize **Stockton Dental Studio**

DENTIST OR DENTAL OFFICE NAME

ADDRESS

CITY

STATE

DATE

PHONE

To disclose

(NAME OF RECIPIENT)

ADDRESS

CITY

STATE

DATE

PHONE

Check the box and initial to specify which type of information is to be disclosed.

Medical Information

START DATE

END DATE

X-RAY Results

START DATE

END DATE

Specify the records to be disclosed:

**Duration:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here.

**Revocation:** This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**Redisclosure:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

DATE

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

DATE

## OFFICE PROCEDURES

- 1 **Phone Confirmations & Cancellations:** We reserve the right to charge a broken appointment fee. It is our procedure that you call 24 hours to cancel your appointment. A charge of \$50 will be billed for broken hygiene appointments. A charge of \$100 will be billed for broken doctor appointments.
- 2 **Verbal Authorization:** It is our office procedure to get verbal authorization from all new patients to confirm appointments and leave messages if patient is not available. Also, patient must call 24 hours in advance to cancel appointments. It is also our procedure that we get your insurance information so we can confirm that status of your insurance and get prior authorization for treatment as needed.
- 3 **I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all my Protected Health Information, Medical and Treatment matters and Billing.**

PERSONAL REPRESENTATIVE PRINTED NAME	RELATIONSHIP	DATE
PRINTED NAME OF PATIENT	DATE	
SIGNATURE OF PATIENT	DATE	

- 4 **I authorize the following named person/persons to authorize medical treatment for my named children. The Doctor and staff may speak freely regarding my child/children's protected health information, medical treatment matters and billing. I understand that I am still responsible for the billing.**

NAME OF AUTHORIZED PERSON	RELATIONSHIP	DATE
PRINTED NAME OF CHILD	PRINTED NAME OF CHILD	
SIGNATURE OF AUTHORIZED PERSON	DATE	

- 5 **I authorize Stockton Dental Studio to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Stockton Dental Studio. I authorize Stockton Dental Studio to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, X-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Stockton Dental Studio's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.**

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS	DATE
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS	DATE

## OFFICE PROCEDURES CONTINUED

- ⑥ Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health information.

However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.

I, agree to all of the above office procedures of Stockton Dental Studio, and give my authorization to all of the above procedures.

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PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

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DATE

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SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

---

DATE

## ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending Doctor, or his Nurse or qualified designate.

I also acknowledge full responsibility for the payment of services and agree to pay for them, in full, AT THE TIME OF SERVICE. Unless I have prepaid for my services prior to treatment. The Stockton Dental Studio may obtain a credit report on me or my guarantor.

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PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

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DATE

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SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

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DATE

## GLOSSARY OF TERMS

**BASIC:** Describes the category of general dentistry which generally covers filling, root canal therapy, deep cleaning also called root planing. Occasionally, it includes single crowns (caps), depending on your insurance.

**CALENDAR YEAR:** The period from January through December of one year.

**CARRIER:** Insurance company is commonly referred as the carrier.

**COPAYMENT:** The cost of your treatment that the insurance company does not cover. This is your responsibility.

**DEDUCTIBLE:** The amount determined by your insurance company that you have to pay before the insurance benefit starts.

**DEPENDENTS:** Dependents are the spouse and children of the subscriber. There are usually age and full-time student status limitations.

**FEE SCHEDULE:** Certain dental insurance plan pays according to a fixed list of fees compiled by the insurance company. This list is not intended to resemble the doctors' fee schedule. The balance is the patients responsibility.

**FISCAL YEAR:** Anniversary of when policy began.

**MAJOR:** Describes the category of general dentistry which generally covers crowns, bridges, partial dentures and full dentures.

**MAXIMUM:** Is the total dollar amount your dental plan will pay toward the cost of care per specified policy year.

**PREDETERMINATION:** Predetermination of benefits is an administrative procedure whereby a dentist submits his treatment plan to the insurance company before treatment is started. Insurance companies make NO guarantee of payment even though a procedure has been authorized.

**PREVENTIVE:** Describes the category of general dentistry which covers exams, x-rays, and routine cleaning.

**SUBSCRIBER:** The person who subscribes to the insurance; usually the employee who represents the family unit in relation to the dental program.

**UCR:** Abbreviation for "Usual, Customary and Reasonable" fee. Very vague term used by insurance companies that represents what they are going to base their benefits upon. It is geographically specific and it varies from one insurance company to another. It is often different from your dentists' fee. The difference is your responsibility.

**WAITING PERIOD:** The time determined by your dental plan that one has to wait before coverage for certain procedures and/or insurance coverage starts.