Dental Expectations/History

Welcome! We're glad you're here.

To better serve you, please take just a couple of minutes to answer the following questions. Thank you!

Name: _____ Date: _____

1. **What would you like to discuss with the Dentist today?** (Check ✓ all that apply)
   - ○ Smile Improvement
   - ○ Braces/Invisalign
   - ○ Replace missing teeth
   - ○ Tooth Ache
   - ○ Bleeding, Swollen, or Irritated Gum
   - ○ Grinding or Clenching teeth
   - ○ Routine Dental Check-up
   - ○ 2nd Opinion
   - ○ Other:_____
     _____

2. **Do you have any missing teeth?**
   - ○ Yes
     - ▪ Do you wear an appliance?
       - ○ Yes [Year Made: _____]
       - ○ No
   - ○ No

3. **Do you currently or have you ever worn braces/invisalign?**
   - ○ Yes
     - ▪ How long ago: _____
     - ▪ Do you currently wear a retainer?
       - ○ Yes
       - ○ No
   - ○ No

4. **Please rate your smile on a scale 1 – 10 (10 being highest): _____**
   If you could change your smile, would you: (Please check ✓ all that apply)
   - ○ Make your teeth whiter
   - ○ Make your teeth straighter
   - ○ Close spaces between teeth
   - ○ Replace black metal fillings with tooth-colored restorations
   - ○ Repair chipped teeth
   - ○ Replace missing teeth
   - ○ Replace old crowns that don't match
   - ○ Have a smile makeover
   - ○ Others:
     _____
     _____

5. **Please share the following approximate dates:**
   - ▪ Your Last Cleaning: _____
   - ▪ Your last complete x-rays: _____

Comfort Dental Care

Patient Registration

About You

First Name: _____ Middle Initial: ___
Last Name: _____
Preferred Name: _____
Birth Date: ____/____/____ Soc Sec: _____
Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed
Address: _____
_____
City: _____
State/Zip: _____
Email: _____
Cell #: _____
Home #: _____
Work #: _____
Drivers Lic: _____
Whom may we thank for referring you: _____
_____

Person Responsible for Account

☐ Patient (Self)
☐ Other (Please provide details below)
First Name: _____
Last Name: _____
Relation to Patient: _____
Phone #: _____
Cell #: _____
Work #: _____
Email: _____
Birth Date: _____/_____/_____
Billing Address: _____
_____
City: _____State/Zip: _____

Emergency Info

Emergency Contact: _____
Emergency Contact #:_____

Primary Insurance (If applicable)

Who is the Policy Holder?
☐ Patient (Self)
☐ Responsible Party is also the Policy Holder
☐ Other (Please provide details below)
First Name: _____
Last Name: _____
Relation to Patient: _____
Phone #: _____
Email: _____
Birth Date: _____/_____/_____
Soc Sec: _____
Address: _____
_____
City: _____ State/Zip: _____

Ins Company: _____
Insured's ID: _____ (if diff than SS)
Insured's Employer Name: _____
Insured's Emp Address: _____
_____

Secondary Insurance (If applicable)

Who is the Policy Holder?
☐ Patient (Self)
☐ Responsible Party is also the Policy Holder
☐ Other (Please provide details below)
First Name: _____
Last Name: _____
Relation to Patient: _____
Phone #: _____
Email: _____
Birth Date: _____/_____/_____
Soc Sec: _____
Address: _____
_____
City: _____ State/Zip: _____

Ins Company: _____
Insured's ID: _____ (if diff than SS)
Insured's Employer Name: _____
Insured's Emp Address: _____
_____

Comfort Dental Care

APPOINTMENT REMINDER, CONFIRMATION & CANCELATION POLICY

Comfort Dental Care has an electronic appointment reminder system to make confirming easier for you.

"AS A COURTESY WE ARE SENDING YOU THESE REMINDERS.
PLEASE RETURN THE COURTESY AND <u>CONFIRM YOUR APPOINTMENT(S)</u>."

1) **EMAIL** – The service will email you a reminder 3 days prior to appointment(s). You will be able to **confirm** the appointment by following directions on email. If you should need to cancel or reschedule the appointment *you will need to call* the office and speak to a staff member.

2) **CALL TO HOME/CELL PHONE** - The service will call you 3 days prior to appointment(s). If no one answers the call, the service will leave a voice message if machine is available. You will be able to **confirm** the appointment(s) if call is answered, by following the prompt. If you should need to cancel or reschedule the appointment(s) *you will need to call the office and speak to a staff member.* Cancelations and rescheduling CAN NOT be made through the service. If reminder is taken from a voice mail, please call with confirmation.

3) **TEXT TO CELL PHONE** - The service will send a text message 3 days prior to appointment(s). You will only be able to confirm by following prompts on the text. If you should need to cancel or reschedule the appointment(s) *you will need to call the office and speak to a staff member.* Cancelations and rescheduling CAN NOT be made through text message or call prompt.

<u>CANCELATION POLICY:</u>

We are aware that your time is valuable and schedules get busy. So as a courtesy, we extend out reminders of your appointment 3 days in advance. Please return the courtesy by confirming the appointments. We require a 48 - hour notice for any rescheduled appointments or cancellations. **<u>There will be a $50.00 minimum charge, if advanced notice is not given</u>**. This fee is determined by the amount of time reserved for appointment(s). If you are unable to contact us directly, please leave a message on answering machine. This will be accepted, as long as the time stamp on message is within the 48-hour period.

Patient/Guardian Signature: _____ Date: _____

Comfort Dental Care

Office, Financial and Insurance Policies

The providers and staff here at Comfort Dental Care take great pride in the quality of care extended to our patients. We feel it is important that our patients are informed in advance of our office, financial and insurance policies. Please read the following policies. Should you have any questions, a staff member will be happy to explain the policy to you.

Payment Modes: Comfort Dental Care accepts cash, money orders, MasterCard, Visa, Discover and American Express credit cards. We also accept CareCredit. Checks are accepted 3 days in advance of service.
Dental Benefit Co-Pays: My co-pay is due at the time of my appointment, unless prior arrangements are made.
Private Pay Accounts: I am responsible, at the time of service, for all expenses incurred during my appointment.
Non-Covered Services: If I select to do any non-covered services, payment will be due at the time those services are rendered. Example of possible non-covered services may be but not limited to the following; nitrous oxide, teeth whitening, pulp caps, Bone Graft, Arestin or any procedure not covered under dental benefit plans.
Returned Check Fees: I understand that if Comfort Dental Care receives a returned check, written towards my/family account, I will be charged a returned check fee of $30.00.
Collection Process: I understand that I will receive account statements from Comfort Dental Care. Should account balance go longer than 90 days without payment, I will receive statement notifying me that I have 7 days in which balance must be paid in full or account will be forwarded to collection agency. If this occurs, I will be subject to a processing fee of $45.00. I will not be allowed to schedule any further appointments, receive any prescriptions (new or refills) or seek any medical advice of any kind from Comfort Dental Care until this collection balance is paid in full.
Dental Benefits (Insurance) Policy: I understand that all fees quoted are only estimates. Comfort Dental Care does not guarantee the amount to be paid by my dental benefit plan. My policy is a contract between me, my employer and the benefit company. Although the staff will obtain eligibly and benefits, it's my responsibility for informing them of any changes to the plan, benefits and/or insurance company prior to my appointment(s). Ultimately, I am responsible for all payments not made by my insurance company.

Notice of Privacy Practices:
I have received a copy of the office's Notice of Privacy Practices _____
Initial

OR

I have been provided the Notice of Privacy Practices to read, but do not want a copy for my own records.

_____
Initials

Patient/Guardian Name: _____ **Date:** _____
Please Print

Patient/Guardian Signature: _____

Comfort Dental Care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ **Email:** _____

Patients Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consents: 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, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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 Notice 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:

Contact Person: Ragini Porwal, DDS
Telephone: (925)-634-5353
E-mail: info@discoverybaydentist.com
Address: 14850 Highway 4, Suite B, Discovery Bay, CA - 94505

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 the Consent before we received your revocation, and that we maydecline to treat you or to continue treating 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 our treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF T H I S CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patients chart.