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: _____

How did you hear about us? _____

_____

Person Responsible for Account

☐ Patient (Self)

☐ Other (Please provide details below)

First Name: _____

Last Name: _____

Relation to Patient: _____

Phone #: _____

Driver Lic: _____

Email: _____

Birth Date: _____/_____/_____

Billing Address: _____

_____

City: _____State/Zip: _____

Emergency Info

Emergency Contact: _____

Emergency Contact #:_____

Primary Dental 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: _____

_____

Medical/Sec Dental 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 REMINDERS/CONFIRMATION:

1) **EMAIL** – The service will email you a reminder 14 days prior to appointment(s). Please 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) **TEXT TO CELL PHONE** - The service will send a few text messages prior to appointment(s). Please reply "YES" or "CONFIRM" to confirm (If Not Confirmed yet).

CANCELLATION POLICY & FEES:

We require that you give our office **3 business days' notice** if you need to reschedule/cancel your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. There will be a **minimum fee of $50.00**. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

(**e.g. Appointments on Monday need to be cancelled by Wednesday of previous week, Tuesday by Thursday of previous week and so on to avoid late cancellation fee**)

I understand and agree to the Office Cancellation Policy.

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.

Payment Modes: We accept Cash, Money Orders, MasterCard, Visa, Discover, American Express credit/debit cards and CareCredit. Checks are accepted 3 days in advance of service.

Patient Co-Pays: All patient estimated portions/co-pay is due at the time of scheduling appointment unless prior arrangements are made.

Non-Covered Services: Patient is responsible for all non-covered services; payment is due at the time those services are scheduled. Common Non-covered services include but are not limited to: Nitrous Oxide, Teeth Whitening, Pulp caps, Bone Graft, Arestin or any procedure not covered under dental benefit plans.

Returned Check Fees: I understand that there is a returned Check Fee of $30 for any returned checks.

Collection Process: I understand that I will receive account statements for Outstanding balance from Comfort Dental Care. Should the 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. It is my responsibility to know my insurance coverage and benefits including copays, deductible & coinsurance. Although the staff will obtain eligibility 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.

Request for copies of Health Information: All requests must be made in writing. Whereas we will try to provide the requested information as soon as we can, however, please allow at least 4 business days to process all such requests.

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.
_____ (Initial)

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: _____Social Sec#: _____

Address: _____

Telephone: _____ Email: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY & FILL INFORMATION REQUESTED

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. In Addition, I hereby authorize you to use or disclose the health information to the following persons as indicated:

Name	Relationship	Provide (Health & Medical Information)	Indicate any confidential Information
		☐	
		☐	
		☐	

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 may decline 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:

Representative's Name: _____ Relationship to Patient: _____