

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Date:

/ /

Patient Information

First Name:		Last Name:		I prefer to be called:	
Sex:	Date of Birth (mm/dd/yyyy): / /	Marital Status:		Social Security #: - -	
Home Phone: - -		Work Phone: - -		Cell Phone: - -	
E-mail Address:					
Home Address:				City:	State: ZIP Code:
Employer's Name:		Employer's Phone: - -			
Student Status:	School Name (if a full-time student):				
Best places and times to contact you:				Send appointment reminders via: Text Message Email Mail	
Please tell us where you heard about us (check all that apply):					
Friend or Relative (name):		Newspaper Ad		TV Ad Ad in Mail	
Saw our Office		Insurance Company		Our Website Search Engine (Google, etc.)	
Other:					
Name of Spouse (or Parent, if a minor):		Spouse/Parent's Employer:		Spouse/Parent Work Phone: - -	
				Spouse/Parent Cell Phone: - -	

Emergency Contact

This should be the nearest relative who does not live with the patient.

First Name:		Last Name:		Relationship to Patient:	
Home Phone: - -		Work Phone: - -		Cell Phone: - -	
E-mail Address:					

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Insurance Company Name:	Insurance Company Phone: - -	
Insured's SSN:			

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Insurance Company Name:	Insurance Company Phone: - -	
Insured's SSN:			

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Hanosh and Hunter Dental Group to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Hanosh and Hunter Dental Group. I permit a copy of this authorization to be used in place of the original. I give Hanosh and Hunter Dental Group, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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Payment

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

Cash

Check

Credit Card

Type:

Credit Card Number:

Expiration:

/

Card Verification Code:

VISA/MC/Discover: 3-digit code printed on back
AmEx: 4-digit code printed on front

Your credit card information is kept on file for outstanding account balances.

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

CareCredit

No-Interest Payment Plans

- Pay for treatment over 6 or 12 months with NO interest.
- As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase.

Would you like to discuss our office's financial policy? Yes No

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a \$25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.50 for a minimum balance of \$25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a \$75.00-\$125.00 fee charged for missed or broken appointments without 48 hours notice. To avoid this charge, kindly give us a minimum of 48 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of \$25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Hanosh and Hunter Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Hanosh and Hunter Dental Group to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):

Date (mm/dd/yyyy):

/ /

Dental History

Previous Dentist

Dentist Name:	Phone: - -
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Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
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Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:

Dental Concerns

Check all that apply.

Have you ever had:

Check all that apply.

Orthodontic treatment	Sleep Study
Periodontal treatment	
Any canker sores or cold sores on your lips, tongue, gums, or body	
A serious injury to the mouth or head? If yes, please describe including cause:	

Medical History

How is your general health? Good Fair Poor

Are you currently under medical treatment? If yes, what for?

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Physician's Name:	Phone: - -	Last Visit: /
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Address:	City:	State:	ZIP Code:
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Do we have permission to contact your doctor regarding your care? Yes No

Have you ever had:

Check all that apply.

Arthritis	Seizures	Abnormal bleeding	Recent weight loss
Arteriosclerosis	Fainting	Ulcers/colitis	Rheumatism
Birth defects	Hearing disorders	Difficulty breathing	Scarlet fever
Cancer	High or low blood sugar	Hospitalized for any reason	Sexually transmitted disease
Emotional problems	Hypotension (low blood pressure)	Emphysema	Sickle cell anemia
Head or face injury	Nervous disorder	Glaucoma	Sinus trouble
Heart murmur/trouble	Rheumatic fever	Thyroid disease	Tattoos/body piercing
History of substance abuse/drug addiction	Heart attack/stroke	Angina	TMD/TMJ (jaw pain)
Kidney problems	Heart surgery	Artificial hip/joints	X-ray or cobalt treatment
Numbness of arms or hands	Pacemaker	Gout	Yellow jaundice
Swollen, still painful joints	Artificial valves	Chest pain	Chronic fatigue syndrome
Allergies	Congenital heart defect	Circulatory problems	Cough-persistent or bloody
Asthma	Mitral valve prolapse	Cold sores	Latex sensitivity
Blood disease	Artificial bones/joints	Congenital heart lesion	Smoker
Diabetes	Shingles	Cortisone medicine	Swelling of feet/ankles
Endocrine problems	HIV/AIDS	Convulsions	Swollen neck glands
Intestinal disorders	Blood transfusions	Herpes	Tonsillitis
Hepatitis A, B, or C	Fever blisters	Leukemia	Tumor or growth on head/neck
Hypertension (high blood pressure)	Sinus problems	Excessive thirst	Easily winded
Liver problems	Sinus problems	Hay fever	Anaphylaxis
Pneumonia	Severe/frequent headaches	Heart disease	Alzheimer's disease
Shortness of breath	headaches	Hives/skin rash	Frequent diarrhea
Anemia	Cancer/chemotherapy	Hypoglycemia	Genital herpes
Bruise easily	Radiation treatments	Irregular heartbeat	Renal dialysis
Dizziness	Psychiatric problems	Lung disease	Spina bifida
Epilepsy	Tuberculosis	Osteoporosis	
	Venereal disease	Pain in jaw joints	
	Hemophilia	Parathyroid disease	

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

Acrylic	Dental anesthetics	Nitrous oxide	Tetracycline
Aspirin	Erythromycin	Novocaine	Valium
Barbiturates (sleeping pills)	Iodine	Penicillin/antibiotics	Xylocaine
Codeine	Latex rubber	Sedatives	
	Metals	Sulfa drugs	

Are you being/have you ever been treated for cancer of any kind? If yes, please explain:

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No

Do you take or have you taken Phen-Fen or Redux? Yes No

Do you smoke or chew tobacco? Yes No

Do you use alcohol, cocaine, or other drugs? Yes No

Do you wear contact lenses? Yes No

Are you on a special diet? Yes No

Have you lost or gained more than 10 pounds in the past year? Yes No

Do you use more than two pillows to sleep? Yes No

Have you ever had any excessive bleeding requiring special treatment? Yes No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

Have you been treated in a hospital in the last five years? Yes No

If female, please mark if you are:

Pregnant - If so, please enter your due date or week #:

Trying to get pregnant Nursing On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? Yes No

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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For office use:

Reviewed by: _____ Title: _____ Date: / /

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders

of courts or administrative agencies

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 30, 2014, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit our office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Hanosh and Hunter Dental Group to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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If signing on behalf of someone, explain your relationship to the patient:

Office Personnel Signature:	Office Personnel Name:	Date: / /
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Dental Materials Fact Sheet

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. Both the public and the dental profession are concerned about the safety of dental treatment and any potential health risks that might be associated with the materials used to restore the teeth. All materials commonly used (and listed in this fact sheet) have been shown through laboratory and clinical research, as well as through extensive clinical use to be safe and effective for the general population. The presence of these materials in the teeth does not cause adverse health problems for the majority of the population. There exist a diversity of various scientific opinions regarding the safety of mercury dental amalgams. The research literature in peer-reviewed scientific journals suggests that otherwise healthy women, children and diabetics are not at increased risk for exposure to mercury from dental amalgams. Although there are various opinions with regard to mercury risk in pregnancy, diabetes, and children, these opinions are not scientifically conclusive and therefore the dentist may want to discuss these opinions with their patients. There is no research evidence that suggests pregnant women, diabetics and children are at increased health risk from dental amalgam fillings in their mouth. A recent study reported in the JADA factors in a reduced tolerance (1/50th of the WHO safe limit) for exposure in calculating the amount of mercury that might be taken in from dental fillings. This level falls below the established safe limits for exposure to a low concentration of mercury or any other released component from a dental restorative material. Thus, while these sub-populations may be perceived to be at increased health risk from exposure to dental restorative materials, the scientific evidence does not support that claim. However, there are individuals who may be susceptible to sensitivity, allergic or adverse reactions to selected materials. As with all dental materials, the risks and benefits should be discussed with the patient, especially with those in susceptible populations. There are differences between dental materials and the individual elements or components that compose these materials.

For example, dental amalgam filling material is composed mainly of mercury (43-54%) and varying percentages of silver, tin, and copper (46-57%). It should be noted that elemental mercury is listed on the Proposition 65 list of known toxins and carcinogens. Like all materials in our environment, each of these elements by themselves is toxic at some level of concentration if they are taken into the body. When they are mixed together, they react chemically to form a crystalline metal alloy. Small amounts of free mercury may be re-released from amalgam fillings over time and can be detected in bodily fluids and expired air. The important question is whether any free mercury is present in sufficient levels to pose a health risk. Toxicity of any substance is related to dose, and doses of mercury or any other element that may be released from dental amalgam fillings falls far below the established safe levels as Stated in the 1999 US Health and Human Service Toxicological Profile for Mercury Update. All dental restorative materials (as well as all materials that we come in contact with in our daily life) have the potential to elicit allergic reactions in hypersensitive individuals. 1 These must be assessed on a case-by-case basis, and susceptible Individuals should avoid contact with allergenic materials. Documented reports of allergic reactions to dental amalgam exist (usually manifested by transient skin rashes in individuals who have come into contact with the material), but they are atypical. Documented reports of toxicity to dental amalgam exist, but they are rare. There have been anecdotal reports of toxicity to dental amalgam and as with all dental material risks and benefits of dental amalgam should be discussed with the patient, especially with those in susceptible populations. Composite resins are the preferred alternative to amalgam in many cases. They have a long history of bio-compatibility and safety. Composite resins are composed of a variety of complex Inorganic and organic compounds, any of which might provoke allergic response in susceptible individuals. Reports of such sensitivity are atypical. However, there are individuals who may be susceptible to sensitivity, allergic or adverse reactions to composite resin restorations. The risks and benefits of all dental materials should be discussed with the Patient, especially with those in susceptible populations. Other dental materials that have elicited significant concern among dentists are nickel-chromium-beryllium alloys used predominantly for crowns and bridges. Approximately 10% of the female population are alleged to be allergic to nickel. 2 The incidence of allergic response to dental restorations made from nickel alloys is surprisingly rare. However, when a patient has a positive history of confirmed nickel allergy, or when such hypersensitivity to dental restorations is suspected, alternative metal alloys may be used. Discussion with the patient of the risks and benefits of these materials is indicated. Dental Amalgam: A scientific review and recommended public health service strategy for research, education and regulation, Dept of Health and Human Services, Public Health Service, January 1993.2 Merck Index 1983. Tenth Edition, M Marsha Windhol, Z (ed). I Acknowledge that I have received and read The Dental Material Facts Sheet from The Dental Board of California dated October 2001 as provided by Hanosh and Hunter Dental Group.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
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