Valencia Periodontics

Specialists in Dental Implants, Periodontology & Laser Gum Therapy

WELCOME TO OUR OFFICE

First Name: ____________________ Last Name: ____________________ Middle Initial: ________

Patient's Date of birth: ________________ Age: __________ Sex: Male Female

Address: ____________________________ City/State: __________________ Zip Code: ________

Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

Driver's License# ________________ Social Security# __________________

Employer: ____________________ Occupation: __________________ Email: ____________________

Spouse: ____________________ Employer: __________________ Occupation: ____________________

REFERRAL INFORMATION

Dentist: ____________________________ Reason for today's visit: ____

Family/Friend: ____________________________ Other: ____

EMERGENCY CONTACT

Name: ____________________________________ Relationship: ________________________________

Home Phone: ____________________ Work Phone: __________________ Cell Phone: ________________

RESPONSIBLE PARTY INFORMATION

Primary Insurance Company: ________________ Subscriber's Name: ________________________

Subscriber's ID: ________________________ Subscriber's Birthdate: ________________________

Patient's Relationship lo Subscriber: Self Spouse Dependent

Secondary Insurance Company: ______________ Subscriber's Name: __________________________

Subscriber's ID: ________________________ Subscriber's Birthdate: ________________________

Patient's Relationship to Subscriber: Self Spouse Dependent

DENTAL HISTORY

Dentist's Name: ________________________________ Last Visit: ________________________________

Are you currently in Pain? Yes No

Do you require Pre-Medication for dental visits? Yes No

If Yes, please list Pre-medication: ________________________

Are you anxious about dental visits? Yes No

Please check the box to indicate if you have ever had any of the following:

__ Bad Breath
__ Bleeding Gums
__ Cigarette, pipe, or cigar smoke
__ Dry Mouth
__ Food Collection between teeth
__ Grinding teeth

__ Gums swollen or lender
__ Jaw pain or tiredness
__ Loose teeth or Fillings
__ Mouth Breathing
__ Mouth pain when brushing
__ Orthodontic Treatment

Other: ____________________________________

How often do you brush? ____________________ Floss? ____________________________

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27421 Tourney Road #250 • Valencia CA, 91355
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WELCOME TO OUR OFFICE

Patient Name: ______________________________

Physician's Name: ___________________________

Birth Date: ______________________

Date of last visit: ____________________

Question			
Are you under a physician's care now?	Yes	No	If yes, please explain: ____________________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ____________________
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ____________________
Are you taking any medications, pills, or drugs?	Yes	No	
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	

Your current health is? Good Fair Poor

WOMEN: ARE YOU

Pregnant/Trying to get pregnant Yes No Due Date: ________

Taking oral contraceptives Yes No Nursing Yes No

PLEASE LIST YOUR CURRENT M E D I C A T I O N S? ____

____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING: **Please Circle**

0 AIDS/HIV Positive	0 Chest Pains	0 Frequent Headaches	0 Irregular Heartbeat	0 Scarlet Fever
0 Alzheimer's Disease	0 Cold Sores/Fever Blisters	0 Genital Herpes	0 Kidney Problems	0 Shingles
0 Anaphylaxis	0 Congenital Heart Disorder	0 Glaucoma	0 Leukemia	0 Sickle Cell Disease
0 Anemia	0 Convulsions	0 Hay Fever	0 Liver Disease	0 Sinus Trouble
0 Angina	0 Cortisone Medicine	0 Heart Attack/Failure	0 Low Blood Pressure	0 Spina Bifida
0 Arthritis/Gout	0 Diabetes	0 Heart Murmur	0 Lung Disease	0 Stomach/Intestinal Disease
0 Artificial Heart Valve	0 Drug Addiction	0 Heart Pace Maker	0 Mitral Valve Prolapse	0 Stroke
0 Artificial Joint	0 Easily Winded	0 Heart Trouble/Disease	0 Pain in Jaw Joints	0 Swelling of Limbs
0 Asthma	0 Emphysema	0 Hemophilia	0 Parathyroid Disease	0 Thyroid Disease
0 Blood Disease	0 Epilepsy or Seizures	0 Hepatitis A	0 Psychiatric Care	0 Tonsillitis
0 Blood Transfusion	0 Excessive Bleeding	0 Hepatitis B or C	0 Radiation Treatments	0 Tuberculosis
0 Breathing Problem	0 Excessive Thirst	0 Herpes	0 Recent Weight Loss	0 Tumors or Growths
0 Bruise Easily	0 Fainting Spells/Dizziness	0 High Blood Pressure	0 Renal Dialysis	0 Ulcers
0 Cancer	0 Frequent Cough	0 Hives or Rash	0 Rheumatic Fever	0 Venereal Disease
0 Chemotherapy	0 Frequent Diarrhea	0 Hypoglycemia	0 Rheumatism	0 Yellow Jaundice

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? Yes No If yes, please explain: ____________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

__ Aspirin	__ Barbiturates	__ Codeine	__ Dental Anesthetics	__ Erythromycin	__ Jewelry or Metals
__ Latex	__ Penicillin	__ Sedatives	__ Sulfa Drugs	__ Tetracycline	

If YES or OTHER please explain : ____

Appointments: A minimum charge will be made for failed or canceled appointments without prior notification of 24 hours. Once an appointment has been made, please remember this time has been reserved for you.

Authorization and release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Valencia Periodontics to release *my* information including the diagnosis and the records of any health practitioners. I authorize and request my insurance company to pay directly to Valencia Periodontics insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient/Parent Signature: ______________________________________ Date: ____________________

Treating doctor has reviewed medical history: ______________________________ Date: ____________________

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NOTICE OF PRIVACY PRACTICE CONSENT (HIPAA)

Patient Name: ____

Our notice of privacy practice consent provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office.

You have the right to request that we, restrict protected health information about you for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form the patient, consents to our use and disclosure of protected health information about you for treatment, payment and health core operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a notice of privacy practices and that you have had the opportunity to review this notice.
- The Practice reserves the right to change the notice of privacy practices.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

My signature below indicates that I have read and understand this consent in its entirety, that my questions have been adequately answered, and that I have received a copy of the notice of privacy practices.

Name of Responsible Party: ____
Please Print

Relationship to Patient: ____
Please Print (Self, Parent Lawful Guardian}

Signature: ______________________________ Date: ______________________

Witness: ______________________________ Date: ______________________

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FINANCIAL RESPONSIBILITY

Patient Name: ____________________________________

As advocates for our patients, we will make every effort to access the maximum benefits allowed under your third-party payer contract (insurance). As a patient in this office, you will receive treatment that is specific to the problems that are noted during your initial examination. In return, your financial responsibility for this treatment will be to the doctor.
We will assist you in obtaining reimbursement from your third party benefits payer (insurance) for port of this responsibility. If you do not have third party coverage, we will gladly discuss other options that are available to you.

It is important that you understand that your benefits contract may have on allowable amount for each procedure. This allowable is determined by the benefit contract you have with the company and does NOT always equal the doctor's fee. The third-party payer may pay a percentage of the allowable. You, are then responsible to Dr. Moshe
Benarroch for payment of the balance. This payment may include your deductible (if not already satisfied), the co-payment, and any remaining portion of the doctor's bill that is not covered (providing we are NOT contracted providers with the benefits payer). The portion estimated to be your responsibility will be due at the time of service.

Many patients have a commonly held misconception that medical and dental benefit policies will pay for their entire treatment. This is incorrect and untrue. Please understand that third-party payment is no longer termed "insurance" as it does NOT guarantee payment of benefits. Financial responsibility for services you receive at the office is yours alone.

Again, we want to assure you that we will make every effort to obtain benefits from your third -party payer. We gladly process your claim but we request that you pay your estimated portion at the time, services are rendered. Although, we strive to get accurate third-party information such information is always an estimate and NOT a guarantee of payment. We thank you for your confidence in our office and look forward to providing you with competent care and courteous service.

I have read the above statement and understand that I am financially responsible to Valencia Periodontics for all the care and services provided to me and/or my dependents.

Name of Responsible Party: ____________________________________
Please Print

Relationship to Patient: ____________________________________
Please Print {Self, Parent, lawful Guardian)

Signature: ____________________________ Date: ____________________

Witness: ____________________________ Date: ____________________