OFFICE POLICIES

Mark A. Stepovich, D.D.S. & Ruhi Patel, D.M.D., PC

Our philosophy is *to provide the highest quality of patient education and dental care to all of our patients.*
To ensure you begin with a positive experience we have prepared the following information for your review Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as tow as possiblee we ask that co-payment be made at the time of service. For your convenience we will provide you an estimate for services in advance of your appointment/s to ensure you the opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request

PAYMENT OPTIONS

you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember, your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage. Not alt services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums. For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile Please identify which form of payment is most convenient for you at the time of service. Cash, Check, Visa, MC, American Express.

Please Note: *A $35. 00 NSF* fee *will* be *charged for all returned checks.*

PAST DUE BALANCES

If applicable, balances owing from a prior visit where insurance is not pending, an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. The office does not carry balances and any **patient balance due over 30 days is subject to finance charges of 18% APR and late fees of $35.00 per month**.

CANCELLATIONS

If you are unable to keep your reserved appointment, we request you provide us with a **48-business hour** advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize that emergencies do occur and we will be flexible under those circumstances; however, other missed appointments without the requested notice may incur an **$90.00 Missed Appointment Fee**. Please be advised that multiple missed appointments without the requested notice may result in dismissal from our practice.

CELL PHONES

We ask that cell phones and pagers be turned *off* at all times while in the treatment area. If being available for an emergency during your reserved appointment is necessary, please leave our office telephone number so you can be reached. Should an unfortunate emergency arise, we would be happy to notify you in the treatment area immediately.

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

My signature indicates that I understand that policies as outlined and any questions I have with regards to office policies have been answered.

Signature of Responsible Party or Patient _____ Date _____

*My **signature indicates that I have reviewed the office policies** with **the responsible party and/or patient.**

Signature of Staff Member or Doctor _____ Date _____

PATIENT INFORMATION & DENTAL HISTORY

Mark A. Stepovich, D.D.S. & Ruhi B. Patel, D.M.D, PC

Patient Name: _____ **DOB:** _____

If patient is a minor, list **parent or guardian**: _____

Responsible party information, if different than patient:

- Name: _____ DOB: _____
- Address: _____
- Phone #: _____ Relationship: _____

Who may we thank for referring you to our practice? _____

What Can we do to help or serve you today? _____

Do you have questions or desires for future dentistry? _____

Dental Insurance Information:

Primary Insurance Co Name: _____ Group# _____

Subscriber Name: _____ DOB: _____

Employer: _____ Subscriber ID# _____

Relationship to patient? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Co Name: _____ Group # _____

Subscriber Name: _____ DOB: _____

Employer: _____ Subscriber ID# _____

Relationship to patient? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Dental History & Information:

1. **Date of last**: Dental **exam**: _____ Dental **x-rays**: _____ **Cleaning**: _____
2. Name of previous dentist: _____ Ph #: _____
3. Are you experiencing any dental pain or discomfort today? Y / N
4. How often do you: **Brush** your teeth? _____ **Floss**: _____
5. Do you use: An **Electric Toothbrush**? Y / N **Water Pick**? Y / N
6. Do you wear a N**ight Guard**? Y / N
7. Have you ever had a serious injury to your head or mouth? Y / N
   If so, describe injury and date injury occurred: _____

Mark all that apply to you in the box below:

☐ Snoring	Sleep Apnea	Mouth Breathing	Pain to chewing, biting, or swallowing
Clenching teeth	Bleeding gums	Ear or Neck Pain	Clicking, popping, or jaw pain
Grinding teeth	Sores/Growths	Hard to Open Mouth	Nervous during dental treatment
Mouth Breathing	Snoring	Sleep Apnea	Nervous during dental treatment

We treat patient information with full confidentiality. As you know, confirmation reminders are a courtesy to our patients, but ultimately you are responsible for keeping track of the time and date you have scheduled. We would like your consent in contacting you to confirm your appointments in a way that works best for you via:

☐ ☐

Text Cell Ph#: ____ OR Email: ____

Medical History Form

Mark A. Stepovich, D.D.S. & Ruhi B. Patel, D.M.D., PC

Name: _____ DOB: _____ Sex: M / F

Address: _____ SS#: _____

Cell Ph: _____ Hm Ph: _____ Email: _____

Emerg Contact: _____ Relationship: _____ Ph: _____

If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, circle *yes or no,* whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? **Y / N**
2. Has there been any change to your health within the past year? **Y / N**
3. Date of last physical exam: _____
4. Are you currently under the care of a physician? **Y / N**

   If so, Condition being treated? _____
5. Name of treating physician: _____ **Ph:** _____
6. Have you had a serious illness, operation, or been hospitalized in the past 5 years? **Y / N**

   If So, please explain: _____
7. Are you currently taking any medications, including non-prescription medications? **Y / N**

   If so, please list medications: _____
8. Are you taking Blood Thinners (Such as Coumadin, Warfarin, Rivaroxaban (Xarelto), Dabigatran (Pradaxa), Clopidogrel (Plavix), Heparin or Aspirin? **Y / N**

   ***If yes, which medication are you taking?** _____
9. Are you taking or scheduled to take, an IV MEDICATION to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Y / N**

   *Some commonly-prescribed drugs include Denosumab (Xgeva), Pamidronate (Aredia) or Zolendronate (Zometa)

   ****If yes, what medication are you taking?** _____ **How many years have you been taking it?** _____
10. Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)? **Y / N**
11. Dou you use Vaping Products? **Y / N**
12. Do you use Controlled Substances (drugs), including marijuana, for either medicinal or recreational reasons? **Y / N**
13. Do you wear contact lenses? **Y / N**
14. Have you ever taken Fen-Phen? **Y / N**
15. Do you wear removable dental appliances? **Y / N**

Women:

16. Are you pregnant? **Y / N**
17. Are you nursing? **Y / N**

18. Are you currently on birth control? **Y / N**

19. Do you have problems associated with your menstrual cycle? **Y / N**

20. Do you currently or have you ever had any of the following? (Please mark all that apply)

AIDS	HIV	Liver disease	Rheumatic heart disease	Mental health issues
Anemia	Jaundice	Swollen ankles	Chest Pain upon exertion	Abnormal bleeding
Arthritis	Seizures	Respiratory issues	Inborn heart defect	Blood transfusion
Asthma	STD	Persistent cough	Neurological disease	Cardiovascular disease
Cancer	Tuberculosis	Persistent diarrhea	Recent weight loss	Persistent cough
Diabetes	Ulcers	Cardiac Pacemaker	Artificial heart valves	Immune system issues
Emphysema	Fainting spells	Sinus issues	Persistent swollen glands	Treatment of tumors or growths
Epilepsy	Hay Fever	Thyroid issues	Damaged heart valves	Shortness of breath when lying down
Hepatitis	Heart murmur	Kidney issues	Low blood pressure	Shortness of breath after mild exercise
Immune system issues	Abnormal bleeding	Blood Transfusion	Treatment of tumors or growths	

21. Are you ALLERGIC to any of the following? (Please mark all that apply)

Local anesthetics Penicillin Sulfa drugs Aspirin Iodine Codeine

Barbiturates Sedatives Sleeping pills Other Narcotics: _____

Any other allergies: _____

Have you ever had any serious trouble associated with any previous dental treatment? **Y / N**

If so, please explain: _____

22. Please list any other disease, condition, or problem not listed above that you think we should know about.

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient signature X _____ Date: _____

Additional list of medications:

_____

_____

_____

_____

For completion of dental staff upon **Medical History Update**

Date of Update	**Comments**	**Signature of Dental Staff**
_____	_____	_____

MARK A. STEPOVICH, D.D.S.

1757 Blossom Hill Rd. #10, San Jose, CA. 95124
408-356-0800

FINANCIAL AGREEMENT & CREDIT CARD AUTHORIZATION

In order to streamline your experience in our dental practice, keep cost to you at a minimum, w**e request all patients to provide a credit card to be kept on file for any patient balances due on your account.**
If you have dental insurance, as a courtesy, we will bill your insurance company for you. Once your insurance company has paid their portion and notified us of the amount of your share of the claim, we will automatically charge your credit card on file for any remaining balance due. You will have also received an explanation of dental benefits from your insurance company and will have been made aware that there is a portion of the fee that is your responsibility, so the charge will not come as a surprise to you. This will be an advantage to you since you will no longer have to write out and mail us checks or call-in credit card payments. It will be an advantage to us as well, since it will greatly reduce the number of statements that we have to generate and send out and phone calls we have to make. Once again, this combination will benefit everybody in helping to keep the cost of dental care down. This will not compromise your ability to dispute a charge or question your insurance company's determination or payment. Co-pays, co-insurance, and any deductible remain due at the time of your visit. Dental care is a personal relationship between a patient and a dentist. While we do not believe dental care is just like any other product, practices of insurance companies have made payment for dental care like any other product or service. We ask your understanding with this policy.

I have read the above and understand my credit card will be charged for any charges, which are the patient's responsibility determined by my insurance.
Furthermore, I understand that if I do not have dental insurance my card listed below will be charged for any treatment rendered by this office, unless another form of payment is rendered at the time of service.

• **REQUESTED CREDIT CARD INFORMATION**: This REQUESTED information is secured in our HIPPA compliant system. I, the undersigned, authorize, Mark A. Stepovich, D.D.S., to charge all outstanding balances and fees to the account listed below. I also agree to this office and financial policy.

Patient Name: _____

Email address: _____

Name on credit card: _____

Card Type: (Visa) (MasterCard) (American Express) (Discover)

Card Number: _____ Exp.Date _____

CVC Code: _____ zip code: _____

Signature: _____Today's Date _____

Consent to Proceed

I authorize **Mark Stepovich, D.D.S. & Ruhi Patel, D.M.D, PC's Dental Office** and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____ **DOB**: _____

Signature:_____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Witness: _____ _____ **Date:** _____

Mark A. Stepovich, D.D.S. & Ruhi Patel, D.M.D., PC

Patient Acknowledge and Receipts

1. DENTAL MATERIALS FACT SHEET

I, _____, acknowledge that I have received from Mark A. Stepovich, D.D.S. & Ruhi Patel, D.M.D., PC a copy of the Dental Materials Fact Sheet dated 2019.

X _____ Date: _____

The following document is the Dental Board of California's Dental Material 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 an endorsement of the content of this document.

2. STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Mark A. Stepovich, D.D.S. & Ruhi Patel, D.M.D., PC, The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices Is also posted in the facility.

Mark A. Stepovich, D.D.S. & Ruhi Patel, D.M.D., PC reserves the right to change the privacy practices that are described In the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hear by specifically authorize disclosure of my protected health care information to the persons indicated below.

☐ ANY MEMBER OF MY IMMEDIATE FAMILY

☐ SPOUSE ONLY: _____

Name of Spouse

☐ OTHER: _____

Name of authorized persons

_____ X_____

Name of Patient or Personal Representative — Signature of Patient or Personal Representative

_____ _____

Date — Description of Personal Representative's Authority

Office use only

Record of Acknowledgement not obtained

PROVIDED PRIOR TO TREATMENT? YES ☐ NO ☐ **Date provided:** _____

REASON FOR DENIAL: ☐ Needs more time to review Statement of Privacy Practices ☐ Unable to sign

☐ Wanted to consult with another person before signing ☐ Reason not given ☐ Other:_____