WELCOME

Bay Area Dental Office

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Name_____ Sex: Δ Male Δ Female
Last First Middle

Address_____ City_____ State____ Zip_____

Birth date _____ Soc.Sec. #_____ E-Mail Address: _____

Home Phone _____ Cell Phone _____ Status: Δ Single Δ Married Δ Child Δ Other

Do you have any Immediate Family who may be a patient at our office? Who? _____

Who may we notify in case of emergency _____ Phone _____

Who may we thank for referring you to our office?

Primary Insurance

Subscriber Name_____ Relationship to Patient Δ Self Δ Spouse Δ Child Δ Other
Last First

Subscriber Birth date _____ Subscriber Social Sec. # _____

Employed by _____ Occupation_____ Work Phone _____

Dental Insurance Company_____ Insurance Phone _____ Group # _____

Is patient covered by additional insurance? Δ Yes Δ No If yes, what is the insurance name?

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Δ Yes Δ No

If yes, describe _____ Are you currently under physician care? Δ Yes Δ No

Have you ever had a blood transfusion? Δ Yes Δ No Have you ever taken Fen-Phen/Redux Δ Yes Δ No

Women: Are you pregnant? Δ Yes Δ No Nursing? Δ Yes Δ No Taking birth control pills? Δ Yes Δ No

Please circle Yes or No whether you have had any of the following:

Yes No AIDS/HIV Positive	Yes No Anaphylaxis	Yes No Anemia	Yes No Arthritis, Rheumatism
Yes No Artificial Joints	Yes No Asthma	Yes No Atopic (allergy prone)	Yes No Blood disease
Yes No Cancer	Yes No Chemical dependency	Yes No Chemotherapy	Yes No Epilepsy
Yes No Back problems	Yes No Cough, Persistent	Yes No Cough up blood	Yes No Diabetes
Yes No Liver Malfunction	Yes No Circulatory treatments	Yes No Fainting	Yes No Heart murmur
Yes No Jaw pain	Yes No Food allergies	Yes No Glaucoma	Yes No Headaches
Yes No High blood pressure	Yes No Nervous problems	Yes No Pacemaker/Heart surgery	Yes No Psychiatric care
Yes No Radiation treatment	Yes No Cortisone treatments	Yes No Rapid weight gain or loss	Yes No Liver disease
Yes No Skin rash	Yes No Tuberculosis	Yes No Rheumatic/Scarlet fever	Yes No Shingles
Yes No Shortness of breath	Yes No Artificial heart valves	Yes No Mitral Valve Prolepses	Yes No Swelling of feet
Yes No Herpes	Yes No Pacemaker	Yes No Spinal Bifida	Yes No Hemophilia/Abnormal bleeding
Yes No Surgical implants	Yes No Respiratory disease	Yes No Hepatitis	Yes No Allergic to Latex, Metal, chemical
Yes No Tobacco habit	Yes No Tonsillitis	Yes No Ulcer/Colitis	Yes No Kidney disease/malfunction
Yes No Heart problems, Describe:_____		Yes No Stroke	Yes No Thyroid disease or malfunction

Do you have any drug allergies? If yes, list all:

_____

Are you currently taking any Medications? If yes, list all:

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used for the dentist to help determine appropriate and healthful dental treatment. If there are any changes in my medical history, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Bay Area Dental Office

1. What is your main goal to accomplish from this initial visit?

_____

2. In what condition do you consider your dental health at this time? Good, Fair, Poor or Very Poor.... why?

_____

3. If a tooth can be saved from being pulled, would you prefer to have it saved?

_____

4. Have you considered having full or partial dentures? Or do you have one already?

_____

5. Do you have family or friends that currently wear dentures or have a fake tooth? Are they happy?

_____

6. Do you notice heavy breath or bleeding gums when you brush or floss you teeth?

_____

7. How happy are you with your SMILE?

_____

8. Do you have any sensitivity or pain when you eat or drink?

_____

9. Do you have any phobias or are you afraid of dental work?

_____

10. How good or bad was your previous dentist?

_____

11. What can we do to make this the best dental experience for you?

_____

12. What can we do for you to make you happy with our office?

_____

29 Birch Street, Suite 1, Redwood City, CA 94062
T: (650) 587-3788, F: (650) 368-0219

Bay Area Dental Office

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HIPPA FORM

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information for:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company):
- The day-to-day healthcare operations of your 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 disclosure of my protected health information and my right under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain 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 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 of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Preference Regarding Communication of Health Information

Who to contact:
I hereby give permission to Bay Area Dental Office and Staff, to disclose and discuss any information related to my medical/dental condition(s) with the following family member(s), relative(s), and/or close personal friend(s).

Name _____ Relationship _____

☐ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

Print Patient's Name _____

Signature _____ **Date:** _____

Bay Area Dental Office

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Oral Cancer Screening Consent Form

We are very concern about oral cancer, and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. The Oral Cancer Foundation estimates that in 2013, 42,000 North Americans will be diagnosed with oral or oropharyngeal cancer. **Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use.**

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life-threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage, seeing changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. The fee for this enhanced examination is $ 25.00. As part of our standard or care and because we care about you. We strongly recommend that you choose this additional screening procedure.

Please sign the area below to consent to this non-invasive procedure and financial responsibility for it.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

☐ **YES, I authorize the office to perform the Velscope examination.**

☐ **NO, I refuse to have the office perform the Velscope examination.**

Patient Name_____

Signature of responsible party_____ **Date**_____

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Financial Policy

Thank you for choosing Bay Area Dental Office. Our Primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, check, Visa, MasterCard, American Express or discover Card

We Offer a 5% Courtesy accounting adjustment to patients who pay for their treatment with cash, check, or credit card prior to start of care for treatment plans $600.00 or more.

- Convenient Monthly Payment Plans[1] from Care Credit (I.D is required)
  - Allow you to pay over time in 6, 12 or 18 months with no interest or down payment.
  - No annual fees or pre-payment penalties

Please note:

Bay Area Dental Office requires payment prior to beginning of your treatment.[2]

For plans requiring multiple appointments, alternative payment arrangements may be provided. For Larger, more comprehensive treatment plans of $1,000 or more, a 50% deposit is required to secure your initial treatment appointment.

We also offer in-house financing for treatments over $600.00. You must leave 50% of total treatment cost as down payment at start of care, and then bi-weekly payments. (I.D. required and a credit card must be left on file or post dated checks to receive in house finance). We charge 5% interest on all past due accounts 2 or more months late.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $65 is charged for patients who miss or cancel appointments without a 24-hour notice.

Bay Area Dental Office charges $45.00 for returned checks.

If you have any questions please do not hesitate to ask. We are here to help you get dentistry you want or need.

X_____/_____/____

Patient Name (Print Name) **Patient, Parent or Guardian Signature** **Date**

[1] Subject to credit approval

[2] If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

[3] However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for your payment of your treatment fees and collection of your benefits directly from your insurance carrier.