Dear Patient,

On behalf of myself and my dental team, I welcome you to our office. We are pleased that you have selected us for your dental needs. We are committed to providing the highest quality oral health care in the most gentle, efficient, and compassionate manner possible. Your dental health is our top priority, so we keep up-to-date on new dental techniques and are continually improving our professional skills. More importantly, we are sensitive to our patients' feelings and encourage open communication about their dental care.

On your first visit, we will listen carefully to your dental concerns and answer all of your questions. You can expect a thorough oral examination, including necessary x -rays, oral cancer screening, temporomandibular joint (TMJ) assessment, and other tools to help us make an accurate diagnosis of the condition of your mouth, teeth, and gums. In most instances, we will determine your dental needs and then discuss the suggested treatment with you to meet your oral health goals.

Please complete the new patient forms, print, sign and bring them to your first visit. As always, personal health information will be kept private in accordance with HIPAA Privacy regulations. If you have dental insurance, please bring your insurance information, including your group number.

We look forward to meeting you personally. Thanks again for your confidence in our dental team. If you have any questions, please feel free to call us at: (310) 979-8345.

Sincerely,

Brentwood Dental Team

Brentwood Dental Group

www.BrentwoodDental.com

We are pleased to welcome you to our practice. Please take a few minutes to fill out this forms as completely as you can.

If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

First Name: _____ MI: ____

Last Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

E-Mail: _____

☐ **Please Include my email in mailing list for special offers.**

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Gender: ○Male ○Female

Marital Status: _____

Birth Date: _____ Age: _____

Social Security Number: _____

Driver's License / ID Number: _____

Employment

Employer: _____

Occupation / Position: _____

Office Address: _____

Emergency Contact / Referral

Person to Contact in Case of Emergency: _____

Emergency Contact Phone: _____

Whom May We Thank for Referring You? _____

INSURANCE

Name of Insurance Plan: _____

Policy / Group No: _____

Person Responsible for Account: _____

Relation to Patient: _____ Birth date: _____

Insured's Employer: _____

Business Phone No: _____

Name of Secondary Insurance, if you have any? _____

_____

Policy / Group No: _____

Dental History

Name of Former Dentist: _____

Previous Dentist Phone: _____

Date of Last Dental Care: _____

Date of last X-Rays: _____

How often do you Brush: _____

How often do you Floss: _____

How may we serve you today? _____

_____

How do you feel about the appearance of your teeth? _____

_____

_____

Brentwood Dental Group

www.BrentwoodDental.com

Kindly check if you have had any of the followings:

Dental History

○Yes ○No Amalgam Fillings	○Yes ○No Food Collection Between Teeth	○Yes ○No Sleep Apnea
○Yes ○No Bad Breath	○Yes ○No Grinding / Clenching Teeth	○Yes ○No Snoring
○Yes ○No Bleeding Gums	○Yes ○No Loose Teeth or Broken Fillings	○Yes ○No Sores / Growths in Mouth
○Yes ○No Clicking / Popping Jaw	○Yes ○No Migraines / Headaches	○Yes ○No Sports Activities
○Yes ○No Sensitivity To Hot / Cold	○Yes ○No Periodontal (Gum) Treatment	○Yes ○No Sports Guard
○Yes ○No Dry Mouth	○Yes ○No Orthodontic (Braces) Treatment	○Yes ○No Teeth Whitening

General Medical History

○Yes ○No Rheumatic Fever	○Yes ○No Heart Problem	○Yes ○No Heart Murmur
○Yes ○No Pacemaker/Heart Surgery	○Yes ○No Artificial Heart Valves	○Yes ○No Shortness of Breath
○Yes ○No Surgical Implants	○Yes ○No Low Blood Pressure	○Yes ○No High Blood Pressure
○Yes ○No Stroke	○Yes ○No Fainting/Dizziness	○Yes ○No Headaches
○Yes ○No Epilepsy	○Yes ○No Kidney Disease/Malfunction	○Yes ○No Swelling of the Feet/Ankle
○Yes ○No Persistent Cough	○Yes ○No Tuberculosis	○Yes ○No Sinus Problem
○Yes ○No Cough Up Blood	○Yes ○No Respiratory Disease	○Yes ○No Tobacco Habit
○Yes ○No Blood Disease	○Yes ○No Liver Disease	○Yes ○No Hepatitis
○Yes ○No Anemia	○Yes ○No Cancer	○Yes ○No Radiation Therapy
○Yes ○No Chemotherapy	○Yes ○No Diabetes	○Yes ○No Parathyroid Disease
○Yes ○No Thyroid Disease	○Yes ○No Stomach Ulcers/Colitis	○Yes ○No Skin Rash
○Yes ○No Food Allergies	○Yes ○No Anaphylaxis	○Yes ○No Metallic Allergies
○Yes ○No Back Problems	○Yes ○No Nervous Problems	○Yes ○No Psychiatric Care
○Yes ○No AIDS/HIV Positive	○Yes ○No Herpes/Genital Herpes	○Yes ○No Venereal Disease
○Yes ○No Cortisone Treatment	○Yes ○No Rapid Weight Gain/Loss	○Yes ○No Glaucoma
○Yes ○No Arthritis	○Yes ○No PHEN-FEN	○Yes ○No Latex Sensitivity

Currently taking medications: _____ Alergies: _____

Are you currently under a physician's care? ○Yes ○No If Yes, For what condition: _____

Dr.'s Name: _____ Dr.'s Phone: _____

Have you had any serious illness or operation? ○Yes ○No If Yes, Please describe: _____

Have you ever had a blood transfusion? ○Yes ○No If Yes, Approximately when? _____

For Women: Are you/Might you be Pregnant? ○Yes ○No Are you Nursing? ○Yes ○No Taking Birth Control Pills? ○Yes ○No

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Brentwood, CA 90049

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Tel: (310) 979-8345
Fax: (310) 979-8346

Please review your form for any errors and proceed to the following section.

Authorization

I have reviewed the information on this questioner, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to 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 whether or not paid by insurance.

I understand that I am responsible for all charges incurred whether or not paid by insurance.

I, the undersigned, give my permission to Brentwood Dental Group to use photographs, audio and video recordings and facsimile images of me, without compensation, for promotional activities.

I further agree to hold Brentwoood Dental Group free and harmless from all claims arising from the use of said photographs, audio and video recordings, and fascimile images when used within the scope described above.

X_____ _____

Signature Date

_____ _____

Doctor's Signature Date

I have been given the copy of notice of HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA)

X_____ _____

Signature Date

We realize that many people are nervous or frightened about going to the dentist. If you have such feelings we would like to help you. Please answer these questions carefully. This information will help us make your dental experience more comfortable. Please check the answer that best describes your feelings. Thank you for your cooperation.

BEHAVIORAL/TREATMENT PLANNING CONSULTATION FORM

1. If you had to go to the dentist tomorrow, how would you feel about it?
   - ○ I would look forward to it as a reasonably enjoyable experience.
   - ○ I wouldn't care one way or the other.
   - ○ I would be a little uneasy about it.
   - ○ I would be afraid that it would be unpleasant and painful.
   - ○ I would be very frightened of what the dentist might do.

2. When you are waiting in the dental office for your turn in the chair, how do you feel?
   - ○ Relaxed
   - ○ Tense
   - ○ A little uneasy
   - ○ Anxious
   - ○ So anxious that I sometimes break out in a sweat or almost feel physically sick.

3. When you are in the dentist's chair waiting while he gets his instruments ready to begin working on your teeth, how do you feel?
   - ○ Relaxed
   - ○ Tense
   - ○ A little uneasy
   - ○ Anxious
   - ○ So anxious that I sometimes break out in a sweat or almost feel physically sick.

4. You are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments, which he will use to clean your teeth around the gums, how do you feel?
   - ○ Relaxed
   - ○ Tense
   - ○ A little uneasy
   - ○ Anxious
   - ○ So anxious that I sometimes break out in a sweat or almost feel physically sick.

5. Have you ever been tense or nervous about your dental therapy? ○ Yes ○ No

6. Has local aneshetic ever failed to work for you? ○ Yes ○ No

7. Have you tried nitrous oxide (laughing gas)? ○ Yes ○ No

8. Was nitrous oxide sufficient to alleviate your anxiety? ○ Yes ○ No

9. Have you ever had intravenous sedation or general anesthesia in a dental office? ○ Yes ○ No

10. Was sedation sufficient to alleviate your pain? ○ Yes ○ No

11. Would you like a consultation with our dentist to discuss specific ways to alleviate pain anxiety for all forms of dental therapy? ○ Yes ○ No

STATEMENT OF FINANCIAL POLICY (Page 1 of 2)

Our office is committed to providing you with the best possible dental care. Your clear understanding of our financial policy is important to our professional relationship. Our office payment policy is that payment is due at time of professional services rendered. In order to assist you better, we provide you with the following payment options for your convenience:

Check, ATM card, cash, Credit Cards (American Express, Master card, Visa, Discover) & *Care Credit (Dental Credit).

*Care credit will provide you with a dental line of credit similar to a credit card. Monthly payments as low as $20.00 may be made toward your initial balance with a minimum of 3 months to a maximum of 12 months interest free, based on your total charge.

I understand that I am personally responsible for the total balance of my dental bill for the services you provide, regardless of my ability to secure credit through payment plan (in house or care credit), or the amount of my available credit on credit card(s) or my ability to make payment at the time of your services, or regardless of how much my insurance policy pays for those services. By providing your office my credit card or care credit information, I authorize you to charge it in the amount of my available credit at the time of running my credit card and if you are not able to charge my card for the total amount of my outstanding balance due, I hereby authorize your office to charge my credit card at a later date when I do have available credit. I understand and acknowledge that no additional authorization will be necessary by your office and that you are authorized by me to charge my credit card without prior notice to me for the balance that I owe to your office.

Patient initial_____

INSURANCE: Due to the unpredictability of insurance reimbursement for dental care, we are not able to determine 100% guarantee of insurance benefits. Our office will retrieve dental benefits and bill your dental insurance company as a courtesy to you. We will collect a copayment based on your dental treatment. All your benefits will be explained to you thoroughly by the front office. Should the insurance differ in payment that was originally expected, the patient will be held responsible for the difference in payment. If your insurance company has not paid the full balance within 30 days, you will have 7 days to pay the balance. If your insurance company pays more than the balance due, we will reimburse you. If your insurance company send the payment to the patients, then patient has to pay the amount to the dental office for the services.

STATEMENT OF FINANCIAL POLICY (Page 2 of 2)

Insurance is a contract between you and your insurance company. We are not a party to this contract. We cannot become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, "usual and customary" charges, effective and termination dates, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account. Our office will assist you in obtaining insurance reimbursement to the best of our abilities.

MISSED APPOINTMENTS: Unless cancelled at least 48 business hours in advance, our policy is to charge for missed appointments at a minimum rate of $50 for each half an hour of regular appointments, depending on the nature of scheduled procedure.

NOTE: This office bills out at an estimated $1000.00 for surgical time when an appointment is cancelled in less than 48 hours prior to appointment date or missed.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.

X_____ _____

Signature Date

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Brentwood, CA 90049

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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 IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

2. OUR LEGAL DUTY

Law Requires Us to:

1.Keep your dental information private.

2.Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.

3.Follow the terms of the current notice.

We Have the Right to:

1.Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

2.Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1.Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and health care operations, we may use and disclose dental information for the following purposes.

3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION (CONTINUATION)

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspection licensure or disciplinary action or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose dental information for the purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2. Receive a list of all the times we or our business associates shared your dental information purposes other than treatment, payment, and health care operation and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address: 11980 San Vicente Bl. Suite 660, Brentwood, CA 90049

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you chose to file a complaint.

Print This Form