# WELCOME

## Patient Information

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Birthdate ______ Age ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

## Dental Insurance

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

## Phone Numbers

Phone (____) ______ Work (____) ______ Ext ______ Alt.Phone (____) ______

Spouse's Work (____) ______ Best time and place to reach you ______

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name ______ Relationship ______

Phone (____) ______ Work Phone (____) ______

## Dental History

Reason for today's visit ______

______

Former Dentist ______

City/State ______

Date of last dental visit ______

Date of last dental X-rays ______

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______



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# Health History

Physician's Name ______________________ Date of last visit ______________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| Condition | Yes | No |
|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |
| Arthritis, Rheumatism | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No |
| Circulatory Problems | ☐ Yes | ☐ No |
| Congenital Heart Lesions | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No |
| Cough, persistent or bloody | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No |
| Fainting or dizziness | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |
| Heart Murmur | ☐ Yes | ☐ No |
| Heart Problems | ☐ Yes | ☐ No |
| Hepatitis Type ______ | ☐ Yes | ☐ No |
| Herpes | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Jaundice | ☐ Yes | ☐ No |
| Jaw Pain | ☐ Yes | ☐ No |
| Kidney Disease | ☐ Yes | ☐ No |
| Liver Disease | ☐ Yes | ☐ No |
| Low Blood Pressure | ☐ Yes | ☐ No |
| Mitral Valve Prolapse | ☐ Yes | ☐ No |
| Nervous Problems | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| Psychiatric Care | ☐ Yes | ☐ No |
| Radiation Treatment | ☐ Yes | ☐ No |
| Respiratory Disease | ☐ Yes | ☐ No |
| Rheumatic Fever | ☐ Yes | ☐ No |
| Scarlet Fever | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |
| Sinus Trouble | ☐ Yes | ☐ No |
| Skin Rash | ☐ Yes | ☐ No |
| Special Diet | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Swollen Feet or Ankles | ☐ Yes | ☐ No |
| Swollen Neck Glands | ☐ Yes | ☐ No |
| Thyroid Problems | ☐ Yes | ☐ No |
| Tonsillitis | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Tumor or growth on head or neck | ☐ Yes | ☐ No |
| Ulcer | ☐ Yes | ☐ No |
| Venereal Disease | ☐ Yes | ☐ No |
| Weight Loss, unexplained | ☐ Yes | ☐ No |

Do you wear contact lenses? ☐ Yes ☐ No

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date ______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## Medications

List any medications you are currently taking and the correlating diagnosis:

______________________________

______________________________

______________________________

Pharmacy Name ______________________

Phone (______)______________________

## Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ______________

______________

## Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

# Medical Center Dental Group

GREGORY LE DMD
11160 Warner Ave. Suite 303
Fountain Valley, Ca . 92708
1 (714) 557-8492 2

**Patient Name** ______________________________

**Terms & Conditions**
As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collection from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.
**Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.
A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.
I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.
In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff. I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office o I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/ or collection fees.
I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matter related to this form.
I have read the above conditions of treatment and agree to their content.

Signed ______________________________ Date ______________ Relationship ______________

**CONSENT FOR TREATMENT:** I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on the Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary pr advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/ or drugs.

**All services are rendered and accepted under the terms and conditions printed on the reverse hereof:**
**Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.**

- ☐ I hereby acknowledge I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way.
- ☐ Patient refused/ was unable to sign because ______________________________
- ☐ I have received a copy of the **Dental Material Fact Sheet** as required by law.

To the best of my knowledge, all of the proceedings answers on the Health History form are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signed ______________________________ Date ______________ Relationship ______________

## RESPECTING THE PRIVACY OF OUR PATIENTS

PRIVACY POLICY OF THE MEDICAL CENTER DENTAL GROUP

We value the trust of our patients and are deeply committed to protecting the privacy of patient information. That is why we only collect and disclose information necessary to provide our patients with quality services. We welcome this opportunity to describe the steps we take to protect our patient's information. Our goal is to ensure that you fully understand our policies and practices regarding the collection, disclosure and protection of this information. You will receive a copy of our privacy statement at the beginning of our doctor-patient, or at your next visit for established patients. The privacy policies described in this statement apply to our current and former patients. It may be necessary to review and revise our privacy policies, in which case we will provide an updated privacy notice.

**Information We Collect** In order to provide high quality services, we must collect and often share information about you and individuals covered under your insurance policy that is not publicly available. We do this to better service patients and process claims in a timely manner. We collect and may share the following types of information about you and your family covered under your policy: **1)** Information about the identity of you and individuals covered under your policy, including the names, address, and social security numbers of such individuals. **2)** Information we receive from you on applications or other insurance and account forms, such as the claims history or medical history of individuals covered under your policy. **3)** Information about your transactions and experiences with us, such as the treatments you received from us, your payment history, account balance, and amounts you paid for your care.

Should we need to verify or obtain additional information about you or individuals covered under your policy, we may contact outside sources, such as agents, brokers, administrators, insurance support organizations, consumer reporting agencies, medical providers and government reporting agencies. Information collected from these outside sources may include employment information and claims or medical reports. Information obtained from outside sources may be retained by these outside sources and disclosed to other persons, in accordance with applicable laws.

**How Such Information Is Used** In many cases, it is necessary to share some or all of the information listed above to help us deliver the best possible services to you and individuals covered under your policy. These disclosures are often necessary to fulfill transactions you have requested and to service the insurance policies that you have applies for and/or purchased. For example, we may share information with your insurance agent or broker, claims adjusters and administrators, claims investigators, and outside companies that perform administrative services on our behalf. We may share information about you and individuals covered under your policy to comply with legal and regulator requirements and for other limited purposes that are required or permitted by law. For example, we may share information about you and individuals covered under your policy to: **1)** Process a transaction that you request. **2)** Protect against fraud or criminal activity. **3)** Report account activity to credit bureaus. **4)** Comply with local, state or federal laws. **5)** Provide information requested by insurers, state insurance regulators and self regulatory organizations, insurance support agencies and law enforcement agencies.

**Under no circumstances do we sell or share patient information to any outside party.**

**Access to and Correction of Individual Information** Individuals covered under your policy may write to us if they have any questions about the information that we may have in our records about them or the identity of those persons to whom their information was disclosed during the two years prior to their request. If they wish, they may review this information in person or receive a copy at a reasonable charge. Individuals covered under your policy can notify us in writing if they believe any information should be correct, amended, or deleted, and we will review their request. We will either make the requested change or explain why we did not do so. If we do not make the requested change, they may submit a short written statement identifying the disputed information, which will be included in all future disclosures of their information.

**Confidentiality and Security of Information** We dedicated significant resources to protect the security of our patient information. We restrict access to customer information to those individuals who need to know that information to provide services to you or individuals covered under your policy. We also maintain physical, electronic, and procedural safeguards to protect patient information, and to guard against is unauthorized use.

**Signature:** ________________________________ **Date:** ________________________

**Medical Center Den Group**
**(714) 557-8492**

# AYMENT POLICY

We work very hard to control the cost of dental care. It is part of our philosophy that quality care should be available to everyone. Our first rule of thumb: before any work is performed, we will sit down together and go over our estimate of charges – every detail.

**We accept and offer the following methods of payment:**

1) **5% courtesy discount**: Enjoy a 5% savings for payment in full when the treatment plan is presented (cash or check only)

2) **Credit cards**: Visa, MasterCard, American Express and Discover are all acceptable forms of payment.

3) **Check payments**: Any payment made via check is electronically debited from your checking account. The check, coupled with a driver's license / ID of the check holder is needed to complete the transaction. Your check will be voided and returned to you immediately for your records and the transaction will be found within the debit portion of your bank statement. Because a withdrawal is being made from your checking account, you are subject to a NSF fee should funds not be available.

4) **½ and ½ option**: This option is applicable on major work that requires lab involvement or appointments that require a longer block of time. ½ of your payment is due when scheduling the appointment and the other ½ is due at your appointment date.

5) **Insurance plans**: We will process your dental claims for you electronically; however, your established co-payment or deductibles are due when, or before, treatment is rendered – depending upon lab involvement.

6) **Alternative financing**: Our office provides up to 12 months interest free financing upon approval and payment plans with interest range up to 60 months.

***It is YOUR responsibility to cover the balance of treatment cost or to cover the entire cost of treatment if your insurance should fail to provide coverage for any reason.***

**A *$50 Non-Refundable fee* will be assessed if any appointment is failed or cancelled with less than 24 hours notice.**

*I have read the above information and understand that I am financially responsible for my account and that any financial information, based upon my insurance (written or verbal), is only an estimate. I agree to be held responsible for any amount that my insurance fails to cover. I agree to comply with the payment policy of this office as listed above.*

_______________________________________ ____________________

*Signature of Patient (or parent if minor)* *Date*

# Medical Center Dental Group

11160 Warner Ave Ste 303
Fountain Valley, CA 92708
(714) 557 - 8492

**Insurance Disclaimer:**
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

**Insurance Liability for Payment:**
Your dental insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures paid by your dental insurance company. If your dental insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

**Beneficiary Agreement:**
I understand that my dental insurance company may deny payment for services and procedures for the reasons stated. If my dental insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my dental insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient / Guardian Signature Date