PATIENT INFORMATION RECORD

The following confidential information is for our records only.

Today's Date: _____ Birthdate: _____ 13 years or under? ____

Patient's Name: _____
Mr. Mrs. Ms. Dr. Other | Last name | First name | Middle name

Name you prefer to use: _____ Best method to reach you: _____

Address: _____
Street | Apt/Condo# | City | State | Zip

Home Phone: ( )_____ Cell Phone: ( )_____ E-mail:_____

Driver's License Number (ID#): _____ Social Security Number: _____/_____/_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Child ☐ Other

Name of Person Responsible for Account: _____ Relationship: _____

Patient's Employer: _____Occupation: _____Work Phone: ( )_____X___

Work Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____ Relationship: _____

Emergency Contact: _____Relationship: _____ Phone: ( )_____

INSURANCE INFORMATION

Insured's Name_____ Relationship: _____ Birthdate: _____SS#:_____/_____/_____

Insured's Employer: _____ Phone: ( ) _____ Name of Insurance Co: _____ ID#: _____

Insurance Address: _____ Insurance Phone #: ( )_____

Do you have Secondary Insurance: ☐ Yes ☐ No

ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT OF FEES. If you have insurance, we will gladly process your forms, but a payment of deductible and/or co-payment is expected on the day of service. If you cannot keep an appointment, please give us 48 hours notice so that the time may be given to another patient.

I understand that any procedure carries some risk. I will give my consent to the dental staff to perform any necessary dental services that I may need only when risks, benefits and alternatives are discussed. I understand and agree to the insurance/financial and cancellation policy. In addition, I herby authorize Nob Hill Dental to sign and submit insurance claims on my behalf. I understand that this authorization will assign all insurance benefits directly to Nob Hill Dental.

Patient's or Legal Guardian's Signature: _____ Name(print): _____ Date: _____

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DENTAL HISTORY

Reason for Today's visit: _____ Date of last dental visit: _____ Date of last dental x-rays: _____

Reason to change dentist: _____ Former Dentist: _____ Phone: ( ) _____

Are you currently in pain? ☐ Yes ☐ No Do you have pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Your sugar intake is? ☐ High ☐ Medium ☐ Low Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Interested in whiter teeth? ☐ Yes ☐ No ☐ Maybe Is there anything you'd like to change about your smile? ☐ Yes ☐ No

How many times a week do you floss? _____ How many times a day do you brush? _____ Do your gums ever bleed? ☐ Yes ☐ No

What type of bristles does your toothbrush have? ☐ Soft ☐Medium ☐ Hard ☐ Not sure

Have you ever had any of the following? ☐ Wisdom teeth surgery ☐ Braces ☐ Gum surgery ☐ Dentures or implants ☐ Mouthguard

Do you clench or grind your teeth? ☐ Yes ☐ No Have you ever had a problem with any previous dental work? ☐ Yes ☐ No

MEDICAL HISTORY

Primary Care Physician: _____ Phone: ( ) _____ Fax: ( ) _____
PCP Address: _____ Date of last visit: _____

Are you currently under the care of a physician due to an illness? ☐ Yes ☐ No
Are you taking any prescription/ over-the-counter **medications** or herbal supplement? ☐ Yes ☐ No
If yes, please list each one: _____

Have you ever taken or are you taking: Bisphosphonates ☐ Yes ☐ No Coumadin/Baby Aspirin ☐ Yes ☐ No
Phen-Fen ☐ Yes ☐ No

For women only: Are you taking birth control pills? ☐ Yes ☐ No Are you pregnant or nursing? ☐ Yes ☐ No

Please mark (X) to your responses to indicate if you have or have not had any of the following:

Abnormal bleeding	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Alcohol/drug abuse	☐ Yes	☐ No	Herpes/Fever blisters	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	HIV+/AIDS	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Infective endocarditis	☐ Yes	☐ No
Artificial joints/bones	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Cancer/chemotherapy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No
Congenital Heart Defect (unrepaired)	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
			Seizures	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Cigarettes/Tobacco use	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Heart surger/transplant	☐ Yes	☐ No	If yes, please list: _____		
Hemophilia	☐ Yes	☐ No	_____		

Are you allergic to any of the following?

Aspirin	☐ Yes	☐ No	Latex Gloves	☐ Yes	☐ No	Other:	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Metals	☐ Yes	☐ No	If yes, please list: _____		
Dental anesthetics	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	_____		
Erythromycin	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No	_____		
Jewelry	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No	_____		

The above information is accurate and complete to the best of knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status.

Patient's Signature:_____ Name (print): _____ Date: _____
(If minor, parent or guardian signature)

Dentist's Signature: _____ Name (print): _____Date: _____

Nob Hill Dental
Maria Pham, DDS
1200 Pacific Ave
San Francisco, CA 94109

Consent for Financial Agreement

If you do not wish to leave a card on file, please just check one box and sign the bottom.

- ❑ I choose to pay upfront with cash / check / debit/credit card (**Mastercard** or **Visa** only)

  C.c. # _____ Exp.Date: _____

  3 digit #_____

- ❑ I choose to have my insurance billed and pay the remaining balance on my debit/credit card (**Mastercard** or **Visa** only)

  C.c. # _____ Exp.Date: _____

  3 digit # _____

For Patients With Insurances:

We will collect your estimated patient portion or co-pay upfront or at the time of services rendered. If the insurance happens to cover more, the overpayment will refund to you. If they cover less than the estimated amount, we will charge your credit card for your remaining balance. We can inform you about the charges;

- ❑ Please charge my credit card without calling for the balance
- ❑ Please inform me prior to the charge
- ❑ Please inform me prior to the charges above_____.

Insurance companies are separate entities that the patients bring along to our office in terms of their financial coverage. As a courtesy to our patients, we will bill your insurance company and follow up. Occasionally, we may need your help to collect payment for the services you had already received. This may actually be more effective since you are the client of the insurance company.

If the insurance company fails to pay the balance after 90 days of the billing, we will ask you to pay the full amount. There will be a late payment charge of 1.5% per month for the outstanding balance.

I understand and agree with the above.

Name_____

Signature_____ Date_____

Nob Hill Dental
Maria Pham, DDS
1200 Pacific Ave
San Francisco, CA 94109

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Social Security: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and insurance operations.

Notice of Privacy Practices:
Our Notice provides a description of our treatment, payment activities, and insurance operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. This states that any information that we receive from you (the patient), we will not sell your information to third-party companies. Everything you do at Nob Hill Dental will be kept confidential and will not be released to any unauthorized person(s).

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Should you have any questions or concerns, you may contact:

Contact: Nob Hill Dental
Address: 1200 Pacific Avenue, San Francisco, CA 94109
Telephone: (415) 673-3311 **Fax:** (415) 673-1632

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action continue treating you if you revoke this Consent.

SIGNATURE

I, (print name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and insurance operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

NOB HILL
DENTAL
Maria Pham, DDS

Our Office Policies

We are dedicated to providing the best possible care for you. If order to accomplish that, we want you to fully understand our office policies.

1. As a courtesy, we contact you **three business days** prior to your appointment as a reminder. If we leave you a message, please confirm your appointment by giving our office a call. If our office is closed, messages may be left on our answer machine. Due to limited availability, if we do not hear from you, your appointment will be canceled 24 hours prior to your scheduled time. You will need to contact the office to reschedule.

2. A "no show" is someone who misses an appointment without canceling **at least two business days** in advance or fails to keep a scheduled appointment. In the event a two business days notice is not given, a **fee of $100 per hour of appointment length will be charged** for missed appointments.

3. Payment is due at the time of service unless arrangements have been made in advance with your carrier or us. We accept Visa, MasterCard, check or cash.

4. **A fee of $25.00 will be charged** for returned checks.

5. Keep in mind that your insurance policy is a contract between you and your insurance company. The dental practice is not a party to this contract. As a service to you, we will file your insurance claim. If your insurance company does not pay the practice within *sixty days*, we will look to you for payment. If we receive a check from your insurer after the sixty day period, we will refund any overpayment to you.

6. We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits. You are required to pay a copayment at the time of your visit for any services not covered by insurance.

7. Not all insurance plans cover every service. In the event of amounts not paid by insurance, you will remain liable for all sums owed for services, treatments, procedures and/or diagnostic methods provided to you (including but not limited to the insurance company declining coverage after initially approving it). Payment is due upon receipt of a statement from our office.

8. It is your responsibility to understand your insurance policy and limitations. Our dental practice will not change any billing information in order to re-bill an insurance company in an effort to gain coverage for the services.

I have read and understand the office policies stated above. I agree to be bound by its terms and am aware that this is an agreement between me and the above office. I also understand that this agreement is separate from my arrangements with my insurance company. The above office may amend such terms at any time.

_____ _____

Patient Signature (Guardian, if minor) Date

_____

Name Printed