DIAMOND BAR DENTAL GROUP
2040 S. BREA CANYON RD. STE#210
DIAMOND BAR, CA 91765

WELCOME TO OUR OFFICE

We would like to take this opportunity to tell you about our office.

Our Office Policy is that "the patient comes first." We will do everything possible to make your dental office experience easy, safe, and comfortable. If you have any suggestions or questions on any aspect of your treatment please speak to one of us. We are here to serve you.

Financial Arrangements: It is customary in professional offices to make financial arrangements prior to treatment. Every effort will be made to assist you with insurance claims, but it is necessary that the patient be primarily responsible for costs. Payment is expected at the time service is rendered. We accept most credit and debit (ATM) cards or a payment plan is available through Care Credit.

INSURANCE: Just as we are responsible for providing the best care, the patient is responsible for all charges incurred. The Delta Dental Insurance Company, the largest dental insurer in California, regulates our fees. Insurance claims are billed daily, as a courtesy, and are based on the information provided.

Please be aware that ALL dental benefits (except orthodontics) are considered under the same yearly benefit package. That means that if your are referred to a specialist, the benefits used in this office are no longer available.

Benefit carriers are required to process all claims within 30 days of receipt. If you do not receive notification from your carrier within that time, please contact them directly. Each patient will be given an estimated percentage of his or her out-of-pocket expense. This fee is only an estimate and not a guarantee of payment from your benefit carrier. Any balance remaining at the end of 45 days will be requested from the patient.

SCHEDULED APPOINTMENTS: Every procedure performed in this office is conducted as out –patient surgery. Due to the increased number of postponed and no-show appointments, we have found it necessary o assess a $75.00 fee for any appointments cancelled or rescheduled without a 48 hour notice (2days).

Our staff had made a promise, professionally and personally, to give you the concern, respect, and care that makes out office a office comfortable and pleasant place to visit. If you find you need to cancel or reschedule give enough warning so we can treat another patient. Appointments cancelled without 48- hour notice will not be rescheduled until cancellation fee is paid.

EMERGENCY PATIENTS: Occasionally we are asked to see a patient with an urgent dental problem. Our goal is to provide relief to these emergency patients while we endeavor to honor our time commitments to our regularly scheduled patients.

THANK YOU: WE appreciate the opportunity to serve your dental needs and your referrals are greatly appreciated.

______________________________ ____________________

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

PATIENT INFORMATION

(This information is necessary for our files and will be considered ***CONFIDENTIAL****)*

Date

Patient's Name ______ LAST ______ FIRST ______ INITIAL Age ______ Patient's Birthday ______ ❑ Male ❑ Female

If patient is a minor, give name of parent or legal guardian ______ Relationship ______

Residence Address ______ STREET ______ CITY ______ ZIP For how long? ______ ❑ Own ❑ Rent

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor Email ______

Driver's License No. ______ Social Security No. ______ Res. Phone ( )

Bank ______ Account No. ______ How long? ______ Cell Phone ( )

Employed by ______ How long? ______ Occupation ______

Business Address ______ STREET ______ CITY ______ ZIP Bus. Phone ( )

Spouse's Name ______ Driver's License No. ______ Soc. Sec. No. ______

Employed by ______ How long? ______ Occupation ______

Business Address ______ STREET ______ CITY ______ ZIP Bus. Phone ( )

Name of nearest relative not living with you ______ Relationship ______

Complete Address ______ STREET ______ CITY ______ ZIP Res. Phone ( )

Name of Physician ______ ADDRESS ______ CITY ______ ❑ I have no physician ( ) TELEPHONE

Former Dentist ______ ADDRESS ______ CITY ______ ( ) TELEPHONE

Why are you changing dentists? ______

Purpose of Appointment ______ Do you wish to speak to the doctor privately? ❑ Yes ❑ No

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain: ______

School Children Attend ______ Whom may we thank for referring you? ______

FINANCIAL INFORMATION

Person responsible for this account ______ Relationship ______ ( ) TELEPHONE

Address ______ STREET ______ CITY ______ ZIP ( ) CELL PHONE

PREFERENCE OF PAYMENT: ❑ Cash on day of treatment ❑ Visa No. ______ EXPIRATION DATE

❑ State Aid No. ______ ❑ Mastercard No. ______ EXPIRATION DATE

Name of insurance company (primary insurance) ______

INSURED PERSON'S NAME ______ BIRTHDATE ______ RELATIONSHIP ______ SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN ______ GROUP NO. ______ PLAN NO. ______ NAME OF UNION ______ LOCAL

Name of insurance company (secondary insurance) ______

INSURED PERSON'S NAME ______ BIRTHDATE ______ RELATIONSHIP ______ SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN ______ GROUP NO. ______ PLAN NO. ______ NAME OF UNION ______ LOCAL

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 collections 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 1½% 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 or 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 matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed ______ Date ______

FORM 100-6 / REV 6/05 / ©2007 DENRAM

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? .... (Yes) No

MEDICAL HISTORY

1. Are you in good health? .... Yes No
2. Date of last physical examination
3. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated?
4. Have you ever had any serious illness or operation? .... Yes No
   If so, what illness or operation?
5. Have you ever been hospitalized? .... Yes No
   If so, what was the problem?
6. Are you taking any ❏ medications, ❏ drugs or ❏ herbs? .... Yes No
   If so, what? What dosage?
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ❏ Yes ❏ No If so, what?
8. Have you ever been premedicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? ❏ Penicillin; ❏ Tetracycline; ❏ Sulfa Drugs; ❏ Aspirin; ❏ Codeine; ❏ Latex; ❏ Other.......... Yes No
   If Other, what drugs?
10. Do you have or have you had any of the following: (Please circle '**Y**' for Yes or '**N**' for No - answer all conditions):

Y N Anemia	**Y N** Implant (s)	**Y N** Head Injuries	**Y N** Drug Addiction	**Y N** Blood Transfusion	**Y N** Excessive Bleeding	**Y N** X-Ray or Cobalt Treatment
Y N Herpes	**Y N** Headaches	**Y N** Heart Failure	**Y N** Kidney Disease	**Y N** Joint Replacement	**Y N** Mitral Valve Prolapse	**Y N** Radiation Treatment of any kind
Y N Stroke	**Y N** Glaucoma	**Y N** Scarlet Fever	**Y N** Chemotherapy	**Y N** Nervous Disorders	**Y N** High Blood Pressure	**Y N** Venereal Disease (Syphilis, Gonorrhea)
Y N Ulcers	**Y N** Tonsillitis	**Y N** Sinus Trouble	**Y N** Stomach Ulcers	**Y N** Tumors or Growths	**Y N** HIV Related Complex	**Y N** Acquired Immune Deficiency Syndrome (AIDS)
Y N Diabetes	**Y N** Hemophilia	**Y N** Heart Murmur	**Y N** Angina Pectoris	**Y N** Allergies or Hives	**Y N** Respiratory Disease	**Y N** TMJ (Temporomandibular Joint) Disorder
Y N Arthritis	**Y N** Cold Sores	**Y N** Liver Disease	**Y N** Mental Disorder	**Y N** Pain in Jaw Joints	**Y N** Epilepsy or Seizures	**Y N** Other
Y N Asthma	**Y N** Emphysema	**Y N** Blood Disease	**Y N** Thyroid Disease	**Y N** Artificial Prosthesis	**Y N** Psychiatric Treatment	
Y N Cancer	**Y N** Rheumatism	**Y N** Heart Ailments	**Y N** Fainting Spells	**Y N** Sickle Cell Disease	**Y N** Hepatitis or Jaundice	
Y N Seizures	**Y N** Chicken Pox	**Y N** Heart Attack	**Y N** Rheumatic Fever	**Y N** Cortisone Medicine	**Y N** Difficulty Swallowing	
Y N Hay Fever	**Y N** Bruise Easily	**Y N** Cerebral Palsy	**Y N** Tuberculosis (T.B.)	**Y N** Allergies to Metals	**Y N** Congenital Heart Lesions	

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes No
    If so, what?
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? ❏ Cigarettes ❏ Cigars ❏ Packs per day .... Yes No
14. Have you ever taken the drugs ❏ Fen-Phen, ❏ Redux or any ❏ diet drugs? .... Yes No
15. (Women) Are you pregnant? If so how many months? Yes No
16. (Women) Do you have any problems associated with your menstrual period? Yes No
17. (Women) Do you take any birth control medication or hormones? .... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? .... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain?
4. How long since your last full mouth X-Rays? ___ Weeks ___ Months ___ Years
5. How long since your last dental treatment? ___ Weeks ___ Months ___ Years
6. Does dental treatment make you nervous? ❏ Slightly ❏ Moderately ❏ Extremely? .... Yes No
7. Would you desire to be pre-sedated? .... Yes No

❏ 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 Materials Fact Sheet** as required by law.
To the best of my knowledge, all of the preceding answers 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.

(A) Date **Signature** Reviewed by Lic. # Date

(B) *UPDATE — Since your last visit (A):*

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date **Signature**

(C) *UPDATE — Since your last visit (B):*

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date **Signature**

REVIEWED BY	***DO NOT WRITE IN THIS SPACE***	(A)	(B)	(C)
(A) ***DATE***	DATE			
(B) ***DATE***	B.P.	/	/	/
	PULSE			
(C) ***DATE***	TEMP			
	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this 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 or 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.

Signed: ____________ **Date:** ______ **Relationship to Patient**

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