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**

Child's Information

DATE _____

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

Child's Name _____ Nickname _____ Age _____ Birthdate _____

Name of child's physician _____ Address _____ Phone _____

Child's former Dentist _____ Address _____ Phone _____

School children attend _____

Purpose of appointment _____

Is this office visit for Emergency Dental Care? _____

Whom may we thank for referring you? _____

PARENT OR GUARDIAN INFORMATION

Parent or guardian's name: _____

Residence Address: _____ City _____ Zip _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Driver's License No: _____ Social Security No: _____ Res. Phone No: _____

Bank _____ Account No: _____ Your Birthday: _____

Father Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: _____

Mother employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: _____

Name of nearest relative Not living with you, and complete address _____ Relationship _____

_____ Res. Phone _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ Phone _____

Preference of payment:

Cash on day of treatment _____ Dental Insurance (Name of Co.) _____

BankAmericard No. _____ If Insurance, Soc. Sec. No. of Insured: _____

Mastercharge No. _____ Medi-Cal or State Aid No. _____

Dental Society Timeplan (Dental Bank Loan) _____ Other _____

Terms and Conditions:

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from 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 services performed without previous financial arrangements must be paid for by cash at the the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. This dental office will help prepare the patients insurance forms to assist in making collections from insurance companies and will credit any such collections to the patients accounts. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimated listed for this dental case can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any futher term or condition and I further agree to pay all costs and reasonable attorney's fees if suit be instituted hereunder.

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.

Signature _____ **Date** _____

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HEALTH QUESTIONNAIRE

Please answer each question. Circle yes or no where applicable.

CHILD'S MEDICAL HISTORY

1. Is child in good health? ..... Yes No
2. Date of child's last physical examination _____
3. Is child now under the care of a physician? ..... Yes No
   If so, what is condition being treated? _____
4. Has child ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Has child ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Is child taking any drugs or medicine? ..... Yes No
   If so, what _____
7. Is child sensitive or allergic to any drugs? ..... Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ ..... Yes No
   If so, what _____
8. Does child have, or has he had any of the following:

☐ Anemia	☐ Blood Diseases	☐ Rheumatism or Arthritis
☐ Heart Ailments	☐ Hepatitis, jaundice or liver disease	☐ Head Injuries
☐ High Blood Pressure	☐ Kidney Disease	☐ Stomach Ulcers
☐ Respiratory Disease	☐ Tumors or Growths	☐ Venereal Disease
☐ Tuberculosis	☐ Radiation treatment of any kind	☐ Epilepsy
☐ Nervous Disorders	☐ Allergies	☐ Mental Disorders
☐ Diabetes	☐ Asthma or Hay Fever	☐ Stroke
☐ Excessive Bleeding	☐ Fainting spells or seizures	☐ None of the above
☐ Rheumatic Fever	☐ Sinus trouble	
☐ None of the above	☐ None of the above	

9. Does child wear a cardiac pacemaker? ..... Yes No
10. Has child had heart surgery? ..... Yes No
11. Does child have any disease, health problem or condition not listed above? ..... Yes No
    If so, explain _____
12. (Female) Is patient pregnant? ..... Yes No
13. (Female) Does patient have any problem associated with her menstrual period? ..... Yes No

CHILD'S DENTAL HISTORY

14. Has child ever had a local anesthetic (Novacaine, etc.)? ..... Yes No
15. Has child ever had any unfavorable reaction from local anesthetic? ..... Yes No
16. Has child had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____
17. How long since child's last Full Mouth X-Rays? _____
18. How long since child's last Dental Treatment? _____
19. Does dental treatment make child nervous? ..... Yes No
    ☐ Do not know; If yes, check: ☐ Slightly ☐ Moderately ☐ Extremely
    If so, explain .....
20. Has your child had previous experience with Nitrous Oxide (Happy Air)? ..... Yes No

Please sign for current year!

Year 1
Date _____ Signature _____

Year 2
Changes in Health _____
Date _____ Signature _____

Year 3
Changes in Health _____
Date _____ Signature _____

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 any treatment; or 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."*

Signed _____ **Date** _____

Relationship _____

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. Consent shall remain in force and in effect until cancelled in writing.