PATIENT INFORMATION

Patient Name _____ Today's Date _____

Phone: Hm ( ) _____ Cell ( ) _____ Birthdate _____

Person to contact in an emergency _____ Emergency Phone _____

Email _____

Home Address _____ Soc. Sec. No. _____

City _____ State _____ Zip _____

Patient's Employer _____ Position _____

Work Address _____ Work Phone _____

City _____ State _____ Zip _____

Spouse's Name _____ Date of Birth _____

Employer _____ Soc. Sec. No. _____

Work Address _____ State _____ Zip _____

How did you hear about our office? _____

If you have dental insurance, please complete the following (if **two** policies, complete both portions):

Insured Employee _____ Insured Employee _____

Insurance Company _____ Insurance Company _____

Group Number _____ Phone _____ Group Number _____ Phone _____

I D Number _____ I D Number _____

I authorize release of necessary information relating to all insurance claims. I understand that I am responsible for all costs not paid by insurance. I authorize insurance proceeds to be paid directly to Dr. Anne Yamane D.D.S.

X _____

Signature of patient

MEDICAL HEALTH HISTORY

The following questions are pertinent to the treatment of your dental condition. Please answer all questions.
All answers are confidential. **In some cases, you must be pre-medicated for all treatment, including routine cleaning.**

	Yes	No
1. Have you been under the care of a medical doctor during the past two years?	☐	☐
If yes, for what? _____		
Physician's Name _____ Phone _____		
2. Have you been hospitalized in the past five years?	☐	☐
If yes, please explain: _____		
3. Are you taking any drugs or medications, including non-prescription and herbal medicines?	☐	☐
If yes, please list all medications: _____		
_____		
_____		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Have you ever had an alcohol or drug related problem?	☐	☐
7. Have you ever taken any medication for osteoporosis? such as: (Fosamax, Boniva, Evista)	☐	☐

8. Are you **allergic** to or have you experienced an **adverse reaction** to any of the following?

	Yes	No		Yes	No		Yes	No
dental anesthetic	☐	☐	penicillin	☐	☐	codeine or other narcotics	☐	☐
aspirin	☐	☐	erythromycin	☐	☐	valium or other sedatives	☐	☐
ibuprofen	☐	☐	other antibiotics	☐	☐	metals (nickel, mercury, etc.)	☐	☐
latex rubber	☐	☐	iodine	☐	☐	other _____	☐	☐

9. Do you **have**, or have you **had** any of the following?

	Yes	No		Yes	No		Yes	No
rheumatic fever	☐	☐	stroke	☐	☐	diabetes	☐	☐
endocarditis	☐	☐	respiratory problems	☐	☐	thyroid disorder	☐	☐
heart valve damage	☐	☐	asthma	☐	☐	liver disease	☐	☐
heart pacemaker	☐	☐	hay fever/allergies	☐	☐	jaundice	☐	☐
heart disease	☐	☐	fainting or dizziness	☐	☐	hepatitis A B C	☐	☐
high blood pressure	☐	☐	neurologic disorders	☐	☐	kidney disease	☐	☐
shortness of breath	☐	☐	epilepsy/seizures	☐	☐	emphysema	☐	☐
chest pains	☐	☐	psychiatric/psychological care	☐	☐	chronic cough	☐	☐
heart attack	☐	☐	nervousness/anxiety	☐	☐	tuberculosis	☐	☐
cancer or tumor	☐	☐	recent weight loss/gain	☐	☐	glaucoma	☐	☐
radiation therapy	☐	☐	AIDS or HIV infection	☐	☐	ulcers	☐	☐
chemotherapy	☐	☐	sexually transmitted disease	☐	☐	other (specify):	☐	☐
artificial heart valve	☐	☐	cold sores/fever blisters	☐	☐			
artificial joint (hip, knee)	☐	☐	arthritis/rheumatism	☐	☐	_____		
						_____		

10. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives (birth control pills)?	☐	☐

PLEASE COMPLETE REVERSE SIDE

DENTAL HEALTH HISTORY

1. Reason for dental visit: ☐ Toothache ☐ Checkup ☐ Cosmetic Consult ☐ Other _____
2. Has your dental care been:

☐ Regular (yearly) ☐ Intermittent (when necessary) ☐ Infrequent (when in pain) **Date of last x-rays:** _____

Previous dentist: _____ Date of last dental visit: _____

	Yes	No
3. Do your gums bleed while brushing or flossing?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck, or jaw injuries?	☐	☐
7. Are your teeth sensitive to any of the following?		
hot or cold liquids/foods	☐	☐
sweet or sour liquids/foods	☐	☐
biting or pressure	☐	☐
tooth brushing	☐	☐
8. Have you ever had difficult dental extractions?	☐	☐
9. Have you ever had prolonged bleeding following dental extractions or other surgery?	☐	☐

	Yes	No
10. Have you ever experienced any of the following problems in your jaw?		
clicking	☐	☐
pain (joint, ear, side of face, neck)	☐	☐
difficulty in opening or closing	☐	☐
difficulty in chewing	☐	☐
11. Do you clench or grind your teeth?	☐	☐
12. Do you have frequent headaches?	☐	☐
13. Have you ever had periodontal care?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement: _____		
15. Do you like your smile?	☐	☐
16. Did you ever have a bad experience in a dental office?	☐	☐
17. Is there anything that concerns you about dental treatment?	☐	☐

If yes to #16 or #17, please explain: _____

These statements are true and complete to the best of my knowledge.

X _____ _____

Signature of Patient, Parent, or Guardian Date

Doctor's Comments: _____

_____ Dr. Signature _____ Date _____

CONSENT FOR TREATMENT

1. I hereby authorize Anne Yamane D.D.S. or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient _____ **Date** _____ **Parent or Resp.** _____ **Relationship** _____

OFFICE FINANCIAL POLICY

Welcome to the office of Anne Yamane D.D.S. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa and Master Card. Care Credit may also be available to you.

Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage, and benefits is your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance wallet card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 - 1½ late charge (18% APR) may be added to my account.

Appointments are reserved exclusive for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening may arise. We reserve the right to charge and collect $75.00 for any broken appointments. Broken appointments are considered those that are missed (no-show) and canceled with less than 48 hour advance notice.

Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

Printed Name	Signature	Date
Patient	Date	
Parent or Responsible Party	Relationship to Patient	

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____

Date: _____