Cajon Dental

Gerard Sabaté, D.D.S.
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PATIENT INFORMATION

NAME _____ MR. MRS. MS. DR. _____ _____ _____
LAST FIRST MIDDLE PREFERRED NAME

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

HOME PHONE _____ BIRTH DATE ____/____/_____ SSN# _____

E-MAIL ADDRESS _____ CELL PHONE _____

IF PATIENT IS A MINOR, PLEASE GIVE PARENT OR GUARDIAN _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

EMERGENCY CONTACT INFO: NAME OF RELATIVE NOT LIVING WITH YOU _____

PHONE NUMBER HOME _____ CELL _____

RESPONSIBLE PARTY INFORMATION

NAME _____ _____ _____ MARITAL STATUS _____
LAST FIRST MIDDLE

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

E-MAIL _____

SOCIAL SECURITY# _____ BIRTH DATE ____/____/_____ DRIVER'S LICENSE _____

YOUR EMPLOYER _____ OCCUPATIO_____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ OCCUPATION _____WK PHONE _____

SPOUSE'S EMPLOYER AND ADDRESS _____

INSURANCE INFORMATION

INSURED'S NAME _____ BIRTHDATE ____/____/_____ SOCIAL SECURITY NO. _____

INSURANCE COMPANY _____GROUP NO. _____ POLICY NO. _____

INSURANCE COMPANY ADDRESS _____

DO YOU HAVE SECONDARY INSURANCE? YES _____ NO_____ IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED'S NAME _____ BIRTHDATE ____/____/_____ SOCIAL SECURITY NO. _____

INSURANCE COMPANY _____ GROUP NO. _____ POLICY NO. _____

INSURANCE COMPANY ADDRESS _____

INSURED'S EMPLOYER _____

FINANCIAL AGREEMENT

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment or any dental treatment performed without prior financial arrangements will be paid for at the time of service. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party is personally responsible for payment of all treatment. A service charge of 21 % per annum may be charged on the unpaid balance of all accounts over 60 days. I understand that when appropriate, credit bureau reports may be obtained. I grant my permission to your office to telephone me at my home or work to discuss matters related to this form or my dental treatment.

_____ _____
PATIENT OR RESPONSIBLE PARTY TODAY'S DATE

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Name_____

MEDICAL INFORMATION

Date of last physical exam _____

1. General health: ☐Excellent ☐Good ☐Fair ☐Poor
2. Name & address of your physician _____

   _____
3. Are you now under the care of a physician? ☐Yes ☐No
4. Do you have any disease, problem, or condition that we should know about?

   _____
5. Have you ever had antibiotic or other pre-medication before dental treatment?

   _____
6. Do you have any type of prosthetic replacements such as valves, joints, and pacemaker?

   _____
7. Do you smoke/use tobacco products? ☐Yes ☐No
8. Are you, or might you be pregnant? ☐Yes ☐No
   If yes, due date? _____

9. Check, if you have had any of the following:

☐Allergies
☐Anaphylaxis
☐Anemia
☐Arthritis, Rheumatism
☐Artificial Heart Valves
☐Artificial joints/pins
☐Asthma
☐Back problems
☐Blood disease
☐Cancer
☐Chemical dependency
☐Circulatory problems
☐Cough, persistent
☐Cough up blood
☐Diabetes
☐Ephedra
☐Epilepsy
☐Fainting
☐Food allergies
☐Glaucoma
☐Headaches
☐Heart murmur
☐Heart problems
☐Hemophilia
☐Herpes
☐Hepatitis A, B or C
☐High Blood Pressure
☐HIV/AIDS
☐Jaw Pain
☐Kidney disease
☐Liver disease
☐Lupus
☐Material allergy - LATEX
☐Mitral valve prolepses
☐Nervous problems
☐Pacemaker/Heart Surgery
☐Psychiatric care
☐Rapid weight gain/loss
☐Radiation treatment
☐Respiratory disease
☐Rheumatic/Scarlet Fever
☐Shingles
☐Shortness of breath
☐Skin rash
☐Stroke
☐Surgical implant
☐Swelling of feet of ankles
☐Thyroid disease
☐Tobacco habit
☐Tonsillitis
☐Tuberculosis
☐Ulcer/Colitis
☐Venereal disease
Other _____
_____
_____

Have you ever taken: ☐Phen-fen ☐Pondimin ☐Redux ☐Boniva ☐Fosamax ☐Actonel

List any medications you are currently taking, if any:
(Please include herbal remedies)

_____

_____

_____

List drug or substance allergies, if any:

_____

_____

_____

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DENTAL INFORMATION

It is important for us to understand your needs and concerns about dental treatment so that we may serve you better.

1. Are you having dental discomfort today?
   ☐Yes ☐ No
2. What treatment would you like done today?
   _____
3. Are you missing teeth other than wisdom teeth or Orthodontic extractions? ☐Yes ☐ No
   Have they been replaced?
   ☐Yes ☐ No
4. Do your gums bleed when you brush or floss?
   ☐Yes ☐ No
5. Are you concerned about gum disease?
   ☐Yes ☐ No
6. Do you have any concerns about the appearance of your teeth? ☐Yes ☐ No
7. Does it hurt to bite or chew?
   ☐Yes ☐ No
8. Does any type of dental treatment make you nervous? ☐Yes ☐ No
   Please describe _____
   _____
9. Do you clench or grind your teeth?
   ☐Yes ☐ No
   Do you wear a night guard or splint?
   ☐Yes ☐ No
10. How do you feel about the overall condition of your teeth and mouth?
    ☐Excellent ☐Good ☐Fair ☐Poor
11. Name of previous dentist:
    _____
    City _____ State_____
    Phone #: _____
12. Reason for changing _____
13. How long since your last dental visit and what type of treatment was done?
14. Have you every had a problem with:
    Local Anesthetic? ☐Yes ☐No
    Previous dental treatment? ☐Yes ☐No
    Cleaning or periodontal therapy?
    ☐Yes ☐No
15. When was your last cleaning or periodontal therapy?
    _____
    _____
16. Do you want to become a regular continuing care patient in our office? ☐Yes☐ No
17. Do you want your mouth properly restored and pain free? ☐Yes☐ No
18. The most important concerns regarding my dental treatment are: _____
    _____
    _____
19. What factors are most important for your satisfaction with our office?
    _____
    _____
20. Do you have any additional concerns or comments?
    _____
    _____

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CONSENT FOR TREATMENT

Name of patient _____

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (Name of patient) _____ dental needs. Date_____

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

3. I agree to the use of aesthetics, 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.

4. 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 that a 1-1.5% late charge (18% APR) may be added to my account.

5. I have received from the office a copy of the dental materials fat sheet as required by law.

Patients Signature _____Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes, are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms or health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected earth information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for such expenses such as copies and staff time. You may also request access by sending us $1.00 for each page, $30.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternate Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide a satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. (Your request must be in writing, and it must be explained why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in a response to a request made by you to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.W. Department of Health and Human Services. We will provide you with the address to file you complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health. We will not retaliate in any way if you chose to file a complaint with us or the U. S. Department of Health and Human Services.

Contact Office: Gerard Sabat é , D.D.S. **Address:** 233 Cajon Street, suite 1 Redlands, CA 92373 **Telephone:** (909) 798-4800

Cajon Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES AND DENTAL MATERIALS FACT SHEET

You may refuse to sign this acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy
Please Print Name

Practices and the Dental Materials Fact Sheet.

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other: (please specify)_____

Cajon Dental

AUTHORIZATION TO USE PHOTOGRAPH

I hereby give Cajon Dental and its subsidiaries and affiliated entities (collectively, "CD) the absolute and irrevocable right and permission, with respect to the photographs that CD has taken of me or that I am submitting with this form: (i) to use, re-use, publish, and re-publish the same in whole or in part, severally or in conjunction with other photographs, in any medium and for any purpose whatever, including (but not by way of limitation) illustration, promotion and advertising and educational purposes.

I hereby release and discharge CD from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel and invasion of privacy.

This authorization and release shall insure to the benefit of the legal representatives, licenses, and assigns of CD, as well as the person(s) for whom CD took photographs. I am over the age of majority. I have read the forgoing and fully understand the contents thereof.

Electronic Signature (required)

By checking the "I agree to the terms and conditions above" checkbox below, entering your full name, and clicking the button labeled "AGREE," you (I) acknowledge that you have read and understand the terms and conditions above, (II) agree to be bound by such terms and conditions, and (III) are signing the agreement using your electronic signature.

Signature _____ Date_____

Cajon Dental

Office Financial Policy

We thank you for choosing us as your dental care provider. We are a team whose primary goal is to deliver the finest and most comprehensive dental treatment to you. To help us accomplish that, we have a financial policy with several options that will help you and/or your family. Please let us know if you have any questions or concerns. We would be glad to discuss these with you personally.

About Insurance

We accept most indemnity insurance plans. As most insurance companies will accept our standard form, we will assist you in completing it. If your insurance company requires using their own form, we will need you to complete and sign it.

Based upon information available about your insurance coverage, we estimate the portion covered by your plan and the patient portion. This portion, deductibles and certain procedure generated laboratory fees are due at the first treatment appointment or at the appointment of each separate procedure regardless of insurance benefits. There are no exceptions. Estimates are subject to confirmation by your insurance company. The final amount due will be determined after receipt of the insurance payment. Any overpayments can be credited to your account for future service, or refunded to you.

Some of the needed services may be non-covered services under your insurance plan. Fees may exceed the maximum set by the individual insurance company.

Payment Options

- Cash, check, or ATM payment as services are provided
- Cash or check payment in full, at, or in advance of initial treatment: 5% courtesy given
- MasterCard, Visa, Discover Card
- Care Credit (ask for an application, or apply on-line)
- Personalized payment plan arranged by Dr. Sabat é

Returned Checks

Returned checks are subject to a fee of $35.00

Minor Patients

The parent/guardian bringing the child in for care is the one financially responsible. We will provide you with duplicate statements if necessary.

Missed Appointments

There will be no charge for cancelling your appointment time with at least 24 hours notice. Repeatedly cancelled or missed appointments will be subject to a minimum charge of $100 per hour of reserved appointment time.

I understand and agree to this financial policy.

_____ Date_____

Cajon Dental

CONSENT FOR PATIENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or if my medications change, I will accept responsibility to inform the doctor and other appropriate staff members at my next appointment. I hereby grant authority to the dentist or appropriate staff members in charge of the care of the patient whose name appears on this form to administer anesthetics, analgesics, and/or sedatives as may be advised for dental treatment. In addition, I give permission for the performance of such procedures and operations as may be recommended in the diagnosis and treatment of this patient. Should I fail to understand the purpose, procedures, or risks of any treatment to be performed, I will request clarification to my satisfaction. All treatment and services are rendered to the patient and accepted under the terms and conditions printed on the Financial Policy.

SIGNATURE _____ Date _____

RELATIONSHIP TO PATIENT _____