Foothill Dental Care
WE CATER TO COWARDS

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ We work with only one patient at a time and do not double book. The time that you reserve with us is yours and yours alone.
- ✓ We strive to be thorough in everything we do and to to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit we will take the time to get to know you and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately 90 minutes.

Enclosed you will find our new patient information forms. Please fill out these forms and bring it with you to your first appointment along with a list of any medications that you take.

We look forward to meeting you,

Sincerely

Wayne Buchanan
Office Manager

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1984 Railroad Ave, Suite B, Livermore, CA 94550 | 925-456-7800

So that we may provide the best possible treatment, we ask that you complete this confidential patient questionnaire. Please read it carefully and print answers to all questions. Thank you.

Personal Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Sex: M F
Birthdate: _____/_____/_____ Social Security No. _____-_____-_____
Employer: _____ Occupation: _____
Business Address: _____
City: _____ State: _____ Zip: _____
If Student, name of school: _____

Phone Numbers

Home: _____
Work: _____
Cell: _____

In case of emergency.
Name: _____
Phone: _____ Relationship: _____

Dental Insurance Information

Primary Insurance
Name of Insured: _____
If not yourself: Social Security No.: _____ Birthdate: ____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Cell Phone: _____ Work Phone: _____
Dental Plan Name: _____ Group #_____
Address: _____
City: _____ State: _____ Zip: _____

Secondary Insurance:
Name of Insured: _____
Social Security No.: _____ Birthdate: ____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Cell Phone: _____ Work Phone: _____
Dental Plan Name: _____ Group #_____
Address: _____
City: _____ State: _____ Zip: _____

How did you hear about us? Internet Mailer Yellow Pages Referred Other
If referred, whom may we thank: _____

I hereby authorize the dentist and the designated staff to perform diagnostic procedures and treatment mutually agreed upon by me as may be required for proper dental care. I attest to the accuracy of the information on this form.

Patient Signature: _____ Date: _____/_____/_____

Dental History

Patient Name	Medical Alert

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of last dental visit _____ Last Dental Cleaning _____ Last full mouth x-rays _____

What was done at your last dental visit? _____

_____

Previous dentist's name _____

Address _____ City _____

State _____ Zip _____ Telephone _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What other dental aids do you use? (Interplak, toothpick, etc.)

_____

Please describe any dental problems you are currently experiencing. _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or other lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth?	Yes	No
(pencils, pipe, pins, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaw, especially in the morning?	Yes	No
Smoke or chew tobacco?	Yes	No
Have any allergies to metals? (nickel, cobalt, etc.)	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or opposing of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all your teeth?	Yes	No
Are you in interested in whitening your teeth?	Yes	No
Are you nervous about dental treatment?	Yes	No

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe: _____

_____

MEDICAL HISTORY

1 Have you been under the care of a medical doctor during the past two years? ..... Yes No

If yes, for what? _____

_____

Physician's Name: _____ Phone: _____

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

2 Have you taken any medication or drugs during the past two years? ..... Yes No

If yes, please list name and dosage _____

_____

3 Are you taking any medications, drugs or pills now? ..... Yes No

If yes, please list name and dosage _____

_____

_____

4 Are you aware of having an allergic or adverse reeactrion to any medication ore substance? ..... Yes No

If yes, please list: _____

_____

5 Have you been a patient in the hospital during the past five years? ..... Yes No

6 Indicate which of the following you have had, or have at present. Circle "Yes" or "No to EACH item.

Heart (surgery), disease, attack)..	Yes	No	Liver disease.....	Yes	No	Hepatitis A (infectious) B (serum)....	Yes	No
Chest pain.....	Yes	No	Diabetes.....	Yes	No	Venereal disease.....	Yes	No
Congenital heart disease.....	Yes	No	Thyroid problems.....	Yes	No	A.I.D.S.....	Yes	No
Heart murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. positive.....	Yes	No
High blood pressure.....	Yes	No	Contact lenses.....	Yes	No	COVID.....	Yes	No
Mitral valve prolapse.....	Yes	No	Emphysema.....	Yes	No	Blood transfusion.....	Yes	No
Artificial heart valve.....	Yes	No	Chronic cough.....	Yes	No	Hemophilia.....	Yes	No
Heart pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle cell disease.....	Yes	No
Rheumatic fever.....	Yes	No	Asthma.....	Yes	No	Bruise easily.....	Yes	No
Arthritis/rheumatism.....	Yes	No	Hay fever.....	Yes	No	Psychiatric/psychological care.....	Yes	No
Cortisone medicine.....	Yes	No	Cold sores/fever blisters....	Yes	No	Yellow jaundice.....	Yes	No
Swollen ankles.....	Yes	No	Allergies or hives.....	Yes	No	Neurological disorders.....	Yes	No
Stroke.....	Yes	No	Sinus trouble.....	Yes	No	Epilepsy or seizures.....	Yes	No
Diet (special/restricted).....	Yes	No	Radiation therapy.....	Yes	No	Fainting or dizzy spells.....	Yes	No
Artificial joint (hip, knee, etc.).....	Yes	No	Chemotherapy.....	Yes	No	Nervous/anxious.....	Yes	No
Kidney trouble.....	Yes	No	Tumors.....	Yes	No	Latex sensitivity or allergy.....	Yes	No

7 Have you taken Bisphosphonate? Yes No

If yes, what dosage: _____

8 Do you use more than two pillows to sleep? ..... Yes No

9 Have you lost or gained more than 10 pounds in the past year? ..... Yes No

10 Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list:_____

_____

11 Women.

Are you: Pregnant? Yes, ____ months No Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

_____

_____

Privacy Policy for Foothill Dental Care

This notice describes how your health information may be used and disclosed and how you can access the information. Please review it carefully.

At our office we keep your health information secure and confidential. The law requires us to maintain your privacy, to give you this notice and to follow the terms of his notice. The law permits us to use or disclose your health information to those involved in your treatment. The following are examples.

- A review of your file by a specialist doctor whom we may involve in your care.
- For payment services we may send a report of your progress to your insurance company.
- For our normal healthcare operations one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- To contact you we may send newsletters or other information. We may make phone calls to remind you of your appointments. If you are not home, we may leave information on your answering machine or with the person who answers the phone.
- In an emergency, we may disclose information to a family member or another person responsible for your care.
- When the law requires it, we may release your information.
- If the practice is sold your information will become the property of the new owner.

Except as described above, this new practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of our health information to another practice. We will mail your files to you. You have the right to see and receive a copy of your records; we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. Any request to make changes must be in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in our file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Wayne Buchanan, at 925-456-7800.

This notice is effective as of April 14, 2003

Acknowledgement

I have received a copy of this Notice of Privacy for Foothill Dental Care.

Signature of Patient: _____ Date: _____

Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____

Foothill Dental Care
WE CATER TO COWARDS

FINANCIAL POLICY

Thank you for choosing us as your Dental Care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to treatment.

All patients must complete our information and insurance form before seeing the Dentist.

INSURANCE

Regarding Insurance Plans where we are a participating provider, *all co-pays and deductibles are due at time of service*. In the event your insurance coverage changes to a plan we are not participating providers, refer to the paragraph below.

We may accept assignment of insurance benefits if benefits are verified. However, we do require deductibles and patient portions to be paid at time of service. Payment may be made by any of the following:

Cash-Debit Cards
Credit Card-VISA, MasterCard, and Discover Card

The Balance of your payments are your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. *Your insurance policy is a contract between you and your insurance company. We are NOT a party to the contract.*

In the event we do accept assignment of benefits from you insurance company, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 30 days of service, the balance will be transferred to your credit card. You will receive a courtesy phone call prior to the charge being applied. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under some insurance plans.

RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area and our quality of practice. You are responsible for payment regardless of any insurance company's arbitrary determination or usual and customary rates.

MISSED APPOINTMENTS/LATE APPOINTMENTS

Appointment times are reserved just for you. Missed or late appointments delay treatment. Please help us serve you better by keeping scheduled appointments. Unless rescheduled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of $200.00 per hour of booked appointment.

Thank you for your understanding of our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy, understand, and agree to the terms.

X_____ **Date** _____

Signature of Patient or Responsible Party

Handle Me With Care

- ○ I gag easily.
- ○ I feel out of control when I am lying down in the dental chair.
- ○ I have not been to the dentist for a long time and I feel uncomfortable about what you will say or think about my teeth and my dental hygiene.
- ○ Pain relief is a top priority to me.
- ○ I don't like shots, or I have had a bad reaction to shots.
- ○ My teeth are very sensitive.
- ○ I don't like the sound of that tool that makes the picking and scraping noise.
- ○ I don't like cotton in my mouth.
- ○ I hate the noise of the drill.
- ○ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ○ I have health problems and questions that we need to discuss.
- ○ I don't like being left alone in the treatment area.
- ○ I have problems with my back.
- ○ I don't like the chair tipped back too far.
- ○ I do not like to see dental instruments.
- ○ Others concerns I would like to talk about.

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