Dental Concepts Eastridge
2220 Eastridge Loop, Suite 1060
San Jose, CA 95122
Telephone: (408) 238-6684
Fax: (408) 238-0502

Financial Policy

To Our Valued Patients:
In order to keep our fees from rising and to keep up with the monumental expenses of bookeeping and billing services, we have the following payment and appointment policies. This will help reduce our overhead, thus passing the saving along to our patients.

(1) In order to keep billing at a minimum, we ask that payment for service be made at the office at the the time services are rendered. Patients with dental insurance will be required to pay their portion including deductible, office visit and estimated copay. We will charge a service fee of $25.00 per billing statement for payments not made on the date of visit.

(2) While filing of insurance claims is a courtesy that we extend to our patients, we **MUST** emphasize that as a dental care providers, our relationship is with the patient, not the insurance company. If your insurance changed, you went to a different provider in the same plan year or insurance fails to make payment to the servie we rendered for any reason, patient is responsible for any unpaid balance in your account.

(3) Orthodontic patients who signed a monthly payment contract with us are required to make to make payment each month regardless if statement is received or not. Orthodontic patients who failed to send monthly payments, will incur a late fee of $15.00 and service fee of $25.00 per month

(4) Patients that applied for Care Credit have to sign a separate financial addendum.

(5) A $50.00 charge will be made for any appointment cancelled without 24 hours notice.

(6) A charge of $25.00 will be made for a returned check

(7) X-ray and record copying fee is $35.00 and require 2 days to process.

I have read the above policies and agreed to abide by them.

_____
Printed Name

_____ _____
Patient/Responsible Party's Signature Date

Welcome!

DENTAL CONCEPTS EASTRIDGE
2200 Eastridge Loop, Suite 1060
San Jose, CA 95122
Tel: (408) 238-6684
Fax: (408) 238-0502

Patient Information Date:_____

Name:_____ Sex: M F Birthdate:_____

___ Minor ___Single ___Married ___Divorced ___Widow ___Separated

Address:_____ Home Phone:_____

City/State/Zip:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Name of Parent/Spouse:_____ Cell Phone:_____

If student, name and address of School:_____

In case of emergency, whom should we contact?

Name: _____ Relationship: _____ Phone number: _____

How did you hear about us?_____

Responsible Party (*IF APPLICABLE*)

Name: _____ Relationship: _____ Birthdate:_____

Address:_____ Cell Phone: _____

City/State/Zip: _____ Home Phone:_____

Employer:_____ Work Phone:_____

Primary Insurance Information

Insured Name_____ Birthdate:_____

Social Security #:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Work Address:_____ City/State/Zip:_____

Name of Insurance Co._____ Group/Policy #:_____

Relationship to patient:_____ Insurance Co. Address_____

City/State/Zip:_____

Secondary Insurance Information (*IF APPLICABLE*)

Insured Name_____ Birthdate:_____

Social Security #:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Work Address:_____ City/State/Zip:_____

Name of Insurance Co._____ Group/Policy #:_____

Relationship to patient:_____ Insurance Co. Address_____

City/State/Zip:_____

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin

Please list: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	**Date**	**Signature of Dentist**	**Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DENTAL CONCEPTS EASTRDIGE
GENERAL CONSENT FOR TREATMENT

1. **DRUGS, MEDICATIONS, AND ANESTHESIA:**

I understand that antibiotics, analgesics, and other medication may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pan, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised no to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their EFFECTS (this includes a period of at least twenty four hours (24) after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness and/or irritation to the area of injection.

I understand that if I select to utilize nitrous oxide (Atarax) or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction or airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(Initials)_____

2. **HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):**

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits.

PERIODONTICS - I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gm surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initials)_____

3. **FILLINGS:**

I have been advised of the need for fillings, either amalgam (silver) or composite (white/plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

(Initials)_____

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZED THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.
I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORKS WITHIHN THE ABOVE AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE, I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND *HAVE* HAD THEM ANSWERED TO MY SATISFACTION.

Signature_____ **Date**_____

Dental Concepts Eastridge
2200 Eastridge Loop, Suite 1060
San Jose, CA 95122
Ph: (408) 238-6684
Fax: (408) 238-0502
Admin@dentalconceptssj.com

I have received a copy of the office's **NOTICE OF PRIVACY PRACTICES.**

_____ _____
Patient/Responsible Party's Signature Date

I have received a copy of the office's **COMPARISON OF INDIRECT RESTORATIVE DENTAL MATERIAL.**

_____ _____
Patient/Responsible Party's Signature Date

For Office Use Only

We attemped to obtain written acknowledgement of receipt of our Notice of Privacy Practice and Comparison of Indirect Restorative Dental Material forms, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowlegment

_____ An emergency prevented us from obtaining acknowlegment

_____ Other (please specify) _____