IDC PATIENT INFORMATION

WELCOME! Thank you for selecting Inland Dental Center. This information is necessary for our files and will be considered **CONFIDENTIAL**

Date ____________

Patient's Name ______________________ (LAST) ______________________ (FIRST) ______ (INITIAL) Social Security Number ____________

Nickname ____________ Sex ☐ M ☐ F Age ______ Patient's Birthday ____________

If patient is a minor, give name of parent or legal guardian ____________ Relationship ____________

Residence Address ______________ (STREET) ______________ (CITY) ______ (ZIP) Residence Phone ( ) ____________

Patient is: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor Occupation ____________

Employed by ____________ How long? ______ Cell Phone ( ) ____________

Business Address ______________ (STREET) ______________ (CITY) ______ (ZIP) Business Phone ( ) ____________

Spouse's Name ____________ Email: ____________

Employed by ____________ How long? ______ Soc. Sec. No. ____________

Occupation ____________

Business Address ____________ Business Phone ( ) ____________

Name of nearest relative not living with you ____________ Relationship ____________

Complete Address ______________ (STREET) ______________ (CITY) ______ (ZIP) Residence Phone ( ) ____________

Name of Physician ______________ (ADDRESS) ______________ (CITY) ______________ (TELEPHONE)

Former Dentist ______________ (ADDRESS) ______________ (CITY) ______________ (TELEPHONE)

Purpose of Appointment ____________

Whom may we thank for referring you? ____________

FINANCIAL INFORMATION

Person responsible for this account ____________ Relationship ____________

Address (if different from above) ______________ (STREET) ______________ (CITY) ______ (ZIP) ______ (TELEPHONE)

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Bank Charge Card ____________

Name of insurance company ____________

______________ (NAME OF INSURED) ______________ (BIRTHDATE) ______________ (RELATIONSHIP) ______________ (SOCIAL SECURITY NO.)

______________ (GROUP NO) ______________ (NAME OF UNION) ______________ (LOCAL)

DO YOU HAVE ADDITIONAL INSURANCE? YES ______ NO ______ IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insurance company ____________

______________ (NAME OF INSURED) ______________ (BIRTHDATE) ______________ (RELATIONSHIP) ______________ (SOCIAL SECURITY NO.)

______________ (GROUP NO) ______________ (NAME OF UNION) ______________ (LOCAL)

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, 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 billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

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:

Signed: ______________________ Date ____________

HEALTH QUESTIONNAIRE

Please answer each question.

MEDICAL HISTORY

1. Are you in good health? .... Yes ____ No ____
2. Date of last physical examination ____________
3. Are you now under the care of a physician? .... Yes ____ No ____
   If so, what is the condition being treated? ____________
4. Have you ever had any serious illness or operation? .... Yes ____ No ____
   If so, what illness or operation? ____________
5. Have you ever been hospitalized? .... Yes ____ No ____
   If so, what was the problem? ____________
6. Are you taking any medication? .... Yes ____ No ____ or any recreational drugs (marijuana, cocaine, etc.)? .... Yes ____ No ____
   If so, what? ____________ What dosage? ____________
7. Are you sensitive or allergic to any drugs? .... Penicillin ☐ Y ☐ N Tetracycline ☐ Y ☐ N Aspirin ☐ Y ☐ N Codeine ☐ Y ☐ N
   Other ☐ Y ☐ N If Other, what drugs? ____________
8. Do you have or have you had any of the following: (Please check ✓ known conditions - Y box for YES, N box for NO)

Y N		Y N		Y N		Y N		Y N		Y N	
☐ ☐	Anemia	☐ ☐	Cold Sores	☐ ☐	Sinus Trouble	☐ ☐	Blood Transfusion	☐ ☐	Pain in Jaw Joints	☐ ☐	X-Ray or Cobalt Treatment
☐ ☐	Herpes	☐ ☐	Hemophilia	☐ ☐	Blood Disease	☐ ☐	Joint Replacement	☐ ☐	Respiratory Disease	☐ ☐	Fainting Spells or Seizures
☐ ☐	Stroke	☐ ☐	Rheumatism	☐ ☐	Drug Addiction	☐ ☐	Nervous Disorders	☐ ☐	Sickle Cell Disease	☐ ☐	Chemotherapy (Cancer, Leukemia)
☐ ☐	Ulcers	☐ ☐	Bruise Easily	☐ ☐	Kidney Disease	☐ ☐	Tumors or Growths	☐ ☐	Tuberculosis (T.B.)	☐ ☐	Radiation Treatment of any kind
☐ ☐	Diabetes	☐ ☐	Head Injuries	☐ ☐	Stomach Ulcers	☐ ☐	Allergies or Hives	☐ ☐	Epilepsy or Seizures	☐ ☐	Hepatitis or Jaundice
☐ ☐	Glaucoma	☐ ☐	Heart Failure	☐ ☐	Angina Pectoris	☐ ☐	Cortisone Medicine	☐ ☐	Psychiatric Treatment	☐ ☐	Venereal Disease (Syphilis, Gonorrhea)
☐ ☐	Arthritis	☐ ☐	Liver Disease	☐ ☐	Mental Disorder	☐ ☐	Excessive Bleeding	☐ ☐	Congenital Heart Lesions	☐ ☐	Acquired Immune Deficiency Syndrome (AIDS)
☐ ☐	Emphysema	☐ ☐	Scarlet Fever	☐ ☐	Thyroid Disease	☐ ☐	Asthma	☐ ☐	Difficulty in Swallowing	☐ ☐	TMJ (Temporomandibular joint)
☐ ☐	Hay Fever	☐ ☐	Chicken Pox	☐ ☐	Cerebral Palsy	☐ ☐	High Blood Pressure	☐ ☐	Heart Ailments or Attack	☐ ☐	Bisphosphonates
☐ ☐	Tonsillitis	☐ ☐	AIDS Related Complex			☐ ☐	Latex Allergy	☐ ☐	Phen-Fen Medication	☐ ☐	Other

☐ Y ☐ N Mitral Valve Prolapse ☐ Y ☐ N Heart Murmur ☐ Y ☐ N Rheumatic Fever ☐ Y ☐ N Artificial Prosthesis

If yes, has your physician ever told you that you must take preventative antibiotics for your dental treatment? .... Yes ____ No ____

9. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes ____ No ____
10. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes ____ No ____
    If so, what? ____________
11. Do you smoke? If yes, how much? ____________ per day .... Yes ____ No ____
12. (Women) Are you pregnant? If so, how many months ____ .... Yes ____ No ____
13. (Women) Do you have any problems associated with your menstrual period? .... Yes ____ No ____
14. (Women) Do you take birth control pills? .... Yes ____ No ____
15. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Bonvia, Aredia, Zometa? .... Yes ____ No ____

DENTAL HISTORY

Have you ever had any unfavorable reaction from a local anesthetic? .... Yes ____ No ____
Have you had any serious trouble associated with any previous dental treatment? .... Yes ____ No ____
If so, explain ____________
Do your gums bleed when you brush? .... Yes ____ No ____ Are your teeth sensitive to heat or cold? .... Yes ____ No ____
Are your teeth sensitive to pressure? .... Yes ____ No ____ Are your teeth sensitive to sweets? .... Yes ____ No ____
Do you grind or clench your teeth? .... Yes ____ No ____ Do you have any fear of dental work? .... Yes ____ No ____
Date of last examination or treatment ____________
How do you feel about the appearance of your teeth? ____________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date ________ **Signature** ____________

REVIEWED BY
YEAR 1

Year 2
Changes in Health ____________
Date ________ **Signature** ____________

YEAR 2

Year 3
Changes in Health ____________
Date ________ **Signature** ____________

YEAR 3

Year 4
Changes in Health ____________
Date ________ **Signature** ____________

REVIEWED BY
YEAR 4

Year 5
Changes in Health ____________
Date ________ **Signature** ____________

YEAR 5

Year 6
Changes in Health ____________
Date ________ **Signature** ____________

YEAR 6

Health Questionnaire MUST be updated every year!

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 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:** ____________
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.

Relationship to the patient: ____________

Inland Dental Center-Heritage Court
44100D Jefferson Street, Suite 404, Indio, CA 92201
(760) 772-0214

INSURANCE AND FINANCIAL OFFICE POLICY

Thank you for choosing Inland Dental Center for your dental needs. Our goal is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. It is our sincere desire that you enjoy a healthy, beautiful smile with respect to your individual budget.

IF YOU HAVE DENTAL BENEFITS, CONSIDER YOURSELF FORTUNATE!

Your dental benefits are based on a contract between your employer and an insurance company. The amount your plan pays for services, your co-payment and any limitations or exclusions are set forth and outlined in that agreement. To avoid surprises on your dental bill, it is important to understand what your insurance will cover and what your financial responsibility will be. While your dental benefits can greatly reduce the cost of your care, it is usually not set up to cover all of your costs. ***If you have any questions regarding your coverage or benefits, please contact your insurance company directly. Should you be unsatisfied with the coverage provided by your insurance, you should let your employer know.***

We currently accept all private care insurance plans as well as most managed care plans. This means we work with literally thousands of companies. We will "estimate" your copay due, however it is not a guarantee of payment. Upon request we can file a "pre-authorization" with your insurance prior to treatment.

Your insurance is billed as a "courtesy". If your insurance payment is not received within 90 days Inland Dental Center reserves the right to collect from you the full balance due and ask you to collect from the insurance company. While this is rare, you must understand that your insurance policy is a contract between you and your insurance carrier. We are not a party to this contract and ultimately you are responsible for all charges incurred in our office.

All insurance copays and deductible must be paid at the time of service.

We accept all major credit and debit cards. We also work with "Care Credit", a company who offers (upon approval) a 12 month "same as cash" or longer terms with an interest-breaking revolving charge designed to meet your treatment plan needs. Please ask one of our patient representatives for an application.

BROKEN APPOINTMENTS: A specific amount of time has been reserved for you and we strongly encourage all patients to make every effort to keep their appointments. If you must change an appointment, please provide 24 hour notice to avoid a cancellation fee of up to ($20).

I have read, understand and accept the financial and office policies.

______________________	______________________
Name of Patient	Office Representative
______________________	______________________
Signature Patient or Parent	Date
______________________	
Date	

INLAND
DENTAL SPECIALTIES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________________

Patient #: ______________________ Social Security #: ______________________

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Monica Dubois**

Telephone: **760.772.0214** Fax: **760.772.0583**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ______________________________ Date: ______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ______________

INLAND
DENTAL SPECIALTIES

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 4/15/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this 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 listed 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: Our dental facility employs an open system of delivering dental care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to accommodate you.

We may use or disclose, as needed, your protected health information in order to support our business activities.

For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in. We may call you by name in the reception room when the doctor is ready to see you and he may have a copy of that day's schedule with your name on it in his operatory. We may use or disclose your protected health information, as needed, to contact you by phone or mail to confirm your dental appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, etc.) for the practice.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

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 reasons 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 of disclosure of your health information, 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 of 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 use or 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 authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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 practically 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 expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $5.00 without x-rays and $10.00 if x-rays are requested. If you request an alternative 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 this 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).

Alternative 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 satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain 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 response to a request you made 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 us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Contact Officer: **Monica Dubois**

Telephone: **760.772.0214**

Address: **44100-D Jefferson Street Suite 404 Indio CA 92201**