Tierrasanta Plaza Dental Care

10715 Tierrasanta Blvd. Suite C

San Diego, CA. 92124

Phone: (858)278-6444 Fax: (858) 279-6444

Email: tierrasantapdc@gmail.com

We warmly welcome you to our office. Please take a few moments to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

Single ❑ Married ❑ Divorced ❑

I prefer to be called: _____ Male Female

Birth Date: ____ / ____ / ____ S.S.#: _____-_____-_____

Home Address: _____

_____

Hm#: (_____)_____-_____ Cell#: (_____)_____-_____

Wk#: (_____)_____-_____ Pgr#: (_____)_____-_____

Email: _____

Employer: _____

Employer's Address: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

_____

Previous / Present Dentist: _____

Last Visit Date: ____ / ____ / ____ Ph#: (_____)_____-_____

Who is responsible for this account?

Name: _____

Relationship: _____

Home Address: _____

_____

Hm#: (_____)_____-_____ Cell#: (_____)_____-_____

Wk#: (_____)_____-_____ Pgr#: (_____)_____-_____

Email: _____

Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____ / ____ / ____

Insured's S.S. #: _____ - _____ - _____

Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____ / ____ / ____

Insured's S.S. #: _____ - _____ - _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relationship: _____

Wk#: (_____)_____-_____ Pgr#: (_____)_____-_____

A note for patients with dental insurance

We will assist you in any way possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays for you are responsible for all fees.

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FINANCIAL POLICY

In order to facilitate access to the very best heath care possible, you may choose from any of the following payment methods:

A) **Pay As You Go** - You may choose to pay your obligation for each visit at the time of service. We accept cash, personal check, Visa, MasterCard, American Express, or up to 12-months interest free financing (see item C.)

B) **Pre-Payment Courtesy** - A pre-payment courtesy of 10% will be subtracted from the total patient obligation (not from any portion due by insurance company) if the patient obligation is paid-in-full at the first treatment visit. This option is only available for treatment greater than $1,000.00.

C) **Up to 12 months Interest Free Financing** - (with loan approval from Care credit.) The office will pay for 3.6, or up to 12 months interest (depending on the amount charged) when your treatment is paid-in-full using Care credit. The application is very brief, and their response time is almost immediate. Please ask for more details.

As a condition of treatment in this office, financial arrangements must be made in advance of any treatment rendered. The total cost of treatment is the financial responsibility of each patient. As a courtesy, we will initially ask you for only the estimated portion of your bill. Please understand that this is only an estimate, and is based solely upon the information given to us by you, or your insurance. All accounts with a balance over 90 days will be charged a finance charge of 1.75 per month. Any account in default, past due balance over 120 days, will be referred to our collection agency. All associated fees with the collection process will be charged to the person financially responsible for such account.

INSURANCE POLICY

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do our best to help you derive the maximum benefits available. However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits:

Accepting Assignment:

Our professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment for treatment. To serve and assist you in utilizing your dental insurance, this office will accept your assignment of benefits. It is your responsibility to provide us with insurance forms assigning payment to this office and you are responsible for balances not covered by your policy on the day of service.

Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and tile insurance company. If you have any questions about the amount your plan will pay or the treatments your plan will cover, you should refer these questions to your employer. We are not responsible for determining what your benefits are to be.

Some policies request a "pre-authorization" before treatment is begun. We will submit a treatment plan for review by your insurance company if this is a requirement.

Please remember that dental insurance is designed to assist people to obtain dental care and rarely covers more than 1/3 to ½ of the total cost of service. There may be a deductible, a co-insurance factor, and a yearly maximum to consider. Most policies cover what they consider a "usual and customary fee." These fees are arbitrarily set by the insurance company, and are not always the same as the fees that may be charged in this office.

The final obligation for dental treatment is between the patient and our office. The insurance company is responsible to the patient, and not to our office. We will assist in any way that we can, but once the carrier has paid their portion of the claim submitted, any difference will be due by the patient upon receipt of our statement. If for any reason we are not in receipt of the insurance carrier's payment 90 days after the claim is submitted, the patient will assume full responsibility of the bill. Our office cannot be responsible if your insurance company denies payment on any claims as our responsibility is to provide the highest standard of care and not only what the insurance company allows.

MISSED APPOINTMENTS

Anytime you are unable to keep a scheduled appointment please contact the office immediately. We ask for a 48-hour notice for cancellations. We realize that emergencies do occur and we will be flexible under those circumstances. A fee of $50.00 will be charged per hour that was reserved for your appointment.

I have read and understand the office policy stated above and agree to accept responsibility as described. I also agree to accept this responsibility for the duration of my care at Dr. Miller's office.

Signature _____

Date _____/ _____/ _____

Medical History

Your current Physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you or do you take Osteoporosis medication (Bisphosphonates)? ☐ Yes ☐ No

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Weeks# _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Herpes/Fever Blisters
Y N Alcohol/Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV+/AIDS
Y N Arthritis	Y N Hospitalized Any Reason
Y N Artificial Bones/Joints	Y N Kidney Problems
Y N Asthma	Y N Latex Allergy
Y N Blood Transfusions	Y N Liver Disease
Y N Cancer/Chemotherapy	Y N Low Blood Pressure
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Nervous/Anxious
Y N Diabetes	Y N Pacemaker
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Emphysema	Y N Radiation Treatment
Y N Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Fainting Spells	Y N Seizures
Y N Frequent Headaches	Y N Shingles
Y N Glaucoma	Y N Sickle Cell Disease
Y N Hay Fever	Y N Sinus Problems
Y N Heart Attack	Y N Stroke
Y N Heart Murmur	Y N Thyroid Problems
Y N Heart Surgery	Y N Tuberculosis
Y N Hemophilia	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Please List any serious medical conditions that you have ever had:

_____

_____

_____

Are you allergic to any of the following:

Y N Asprin	Y N Erythromycin
Y N Tetracycline	Y N Latex
Y N Codeine	Y N Sulfa
Y N Dental Anesthetics	Y N Penicillin
Y N Ibuprofen	Y N Iodine

Please list any other drug you are allergic to: _____

_____

Dental History

Why have you come to the dentist today? _____

_____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? ☐ Yes ☐ No

If yes, please explain: _____

How would you describe the condition of your teeth and gums? ☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums? ☐ Yes ☐ No If yes, please explain: _____

Do you want fresher breath? ☐ Yes ☐ No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? ☐ Yes ☐ No Floss your teeth? ☐ Yes ☐ No

Have you ever experienced pain in your jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you grind or clench your teeth? ☐ Yes ☐ No

Please list any other dental conditions that you have, that are not mentioned above:

_____

_____

Have you had any problems with any previous dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

Are you interested in straightening your teeth? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

If you could change your teeth or smile, what would you change?

_____

_____

What are your hobbies or special interests? (sports, self-improvement, education, etc.)

_____

_____

_____ _____

Dentist Date

I understand that the information is correct to the best of my knowledge; I understand it will be held in the strictest of confidence and it's my responsibility to inform this office of any changes in my medical status. 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 authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent, I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing or education purposes.

Signature _____ **Date** _____

Patient Portion is due in full at time of treatment!

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information that you have entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that may affect your rights.

PROTECTING YOUR PERSONAL INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment and dental care protocol. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. Of course, you may give written authorization for us to disclose your information to anyone you choose, for any purpose.
Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to former, current and future employees, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operation and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment information, medical history, health records, etc. While most of the information will be collected from you, personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental personnel under certain circumstances. We will not use your information for marketing purposes without your written consent.
We may use and/or disclose your health information to communicate reminders about your appointments including voice messages, answering machines and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety, of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected Information for uses other than stated above. All such requests must be in writing. We may charge you for copies in the amount allowed by law. If you believe your rights have peen violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Signature _____

Printed Name _____

Date _____/ _____/ _____