

**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 health 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 the 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 1/2 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 \$65.00 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 2<sup>nd</sup> 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 been 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 \_\_\_\_/\_\_\_\_/\_\_\_\_