Welcome!

Concord Dental Care
G. Allen Herrera, D.D.S.

PATIENT INFORMATION

Mr / Mrs / Ms _____

Prefers to be called _____

Address _____

City _____ State _____ Zip _____

Birthdate ____ /____ /_____ Age _____

SSN # _____

Occupation _____

Employer /School _____

Address _____

Spouse or Parent's Name _____

CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

e-mail _____

In case of Emergency, contact:

Name _____ Phone _____

Relationship to Patient _____

HOW DID YOU HEAR OF US?

☐ Family ☐ Friend ☐ Co-Worker ☐ Insurance

Name _____

DENTAL INSURANCE

If not yourself, who is responsible for your account?

Name _____

Address _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Co. _____

Ins. Phone _____

Subscriber's Name _____

Birthdate _____ SSN/ID# _____

Group # _____

Employer Name _____

SECONDARY INSURANCE (If applicable)

Insurance Co. _____

Ins. Phone _____

Subscriber's Name _____

Birthdate _____ SSN/ID# _____

Group # _____

Employer Name _____

DENTAL HISTORY

Please list any dental problems or concerns: _____

Date of last Dental visit ____ /_____ Date of last Dental cleaning ____ /_____ Date of last Dental X-rays ____ /_____

Name of previous dentist _____ City _____ State _____

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No If yes, what are you least happy about? _____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No If yes, please describe: _____

Place a "✓" next to each item to indicate if you have or have had any of the following:

☐ Sensitive to sweets	☐ Loose or broken teeth/fillings	☐ Ear aches, neck pain	☐ Lip or cheek biting
☐ Sensitive to hot	☐ Burning sensation on tongue	☐ Jaw pain or soreness	☐ Difficulty opening/closing
☐ Sensitive to cold	☐ Trapped food between teeth	☐ Jaw clicking, popping	☐ Dry mouth
☐ Sensitive to biting or chewing	☐ Swollen, sore, bleeding gums	☐ Grinding / clenching	☐ Braces, retainers, guards
☐ Bad breath or bad tastes	☐ Periodontal (gum) surgery	☐ Mouth Breathing	☐ Sores on lips or mouth

MEDICAL INFORMATION

Please stop and see the receptionist if you answer "yes" to any of the following: Do you or have you had:

Active Tuberculosis ☐ Yes ☐ No
Cough with blood ☐ Yes ☐ No
Persistent cough 3weeks ☐ Yes ☐ No

Instructions: Check all items that you currently have or have had in the past.

AIDS/HIV ☐ Yes ☐ No
Allergies (hay fever) ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Angina (Chest pains) ☐ Yes ☐ No
Anorexia / Bulemia ☐ Yes ☐ No
Arteriosclerosis ☐ Yes ☐ No
Arthritis / Gout ☐ Yes ☐ No
Artificial heart valves ☐ Yes ☐ No
Artificial joints (hip, knee) ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Blood Pressure (High / Low) ☐ Yes ☐ No
Blood transfusion ☐ Yes ☐ No
Bleeding(abnormal, irregular) ☐ Yes ☐ No
Bruising easily ☐ Yes ☐ No
Cancer, tumors, growths ☐ Yes ☐ No
Chemotherapy (cancer) ☐ Yes ☐ No
Chest pain upon exertion ☐ Yes ☐ No
Cholesterol (High, Low) ☐ Yes ☐ No
Chronic pain ☐ Yes ☐ No
Cold sores, herpes (lips) ☐ Yes ☐ No
Congenital heart defect ☐ Yes ☐ No
Congestive heart failure ☐ Yes ☐ No
Coronary artery disease ☐ Yes ☐ No
Damaged heart valves ☐ Yes ☐ No
Diabetes, childhood/adult ☐ Yes ☐ No
AIC _____ Blood glucose _____
Epilepy / Seizures ☐ Yes ☐ No
Excessive Thirst ☐ Yes ☐ No
Fainting spells / dizziness ☐ Yes ☐ No
GERD (Acid Reflux) ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Headaches / Migraines ☐ Yes ☐ No
Heart arrhythmias ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No
Heart disease ☐ Yes ☐ No
Heart murmur ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Hepatitis / liver disease ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No
Immunosuppresion ☐ Yes ☐ No
Intestinal disease ☐ Yes ☐ No
Jaw Pain / TMJ / TMD ☐ Yes ☐ No
Kidney problems ☐ Yes ☐ No
Lupus (SLE) ☐ Yes ☐ No
Mitral valve prolapse ☐ Yes ☐ No
Muscle pain/Fibromyalgia ☐ Yes ☐ No
Neurological disorders ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Parathyroid problems ☐ Yes ☐ No
Psychiatric care ☐ Yes ☐ No
Radiation (cancer) ☐ Yes ☐ No
Recurrent infections ☐ Yes ☐ No
Respiratory Disease (Emphysema, COPD) ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
STD ☐ Yes ☐ No
Sinus pressure, aches ☐ Yes ☐ No
Sleep apnea, restless ☐ Yes ☐ No
Sores/ulcers in the mouth ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swollen neck glands ☐ Yes ☐ No
Thyroid problems ☐ Yes ☐ No
Tonsilitis ☐ Yes ☐ No
Urination, excessive ☐ Yes ☐ No
Weight loss, rapid ☐ Yes ☐ No

1. Is your overall health good? ☐ Yes ☐ No Last medical check-up _____
2. Have you been hospitalized within the last three years? ☐ Yes ☐ No Why? _____
3. Do you need antibiotics before your dental visit? ☐ Yes ☐ No ☐ I don't know Why? _____
4. What medications or vitamins do you take now? _____
5. Do you smoke or chew tobacco? ☐ Yes ☐ No How often? _____ /day
6. Have you or do you currently use non-prescribed drugs? ☐ Yes ☐ No
7. Have you taken bisphosphonates (Fosamax, Boniva, Prolia) or diet drugs (Fen-phen, Redux)? _____
8. Have you ever had an **allergic or adverse** reaction to: (Check all that apply) ☐ aspirin ☐ ibuprofen ☐ codeine ☐ iodine ☐ local anesthetics ☐ penicillin/amoxicillin ☐ sulfa drugs ☐ tetracycline ☐ latex, plastic or metals ☐ other
9. Women: Are you Pregnant? ☐ Yes, due on _____ ☐ Maybe ☐ No Are you Nursing? ☐ Yes ☐ No
10. Do you have any disease, medical conditions, or problem not listed? _____

I understand that 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. **I will notify the doctor of any change in my health or medication.**

Patient / Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

SCHEDULING AGREEMENT

We take pride in scheduling appointments that fit into your busy schedule. Because your appointment is reserved specifically for your needs, we request at least **24-hours advance notice** if you must change, cancel or reschedule your appointment.

Please be advised that a change or cancellation with less than 24-hours notice of your scheduled appointment will result in a non-refundable missed appointment charge of $75.00 per hour for hygiene, $150 per hour for restorative, $250 per hour for surgery.

As a courtesy, we will try to send you a reminder in advance to remind you of your appointment, however, it is your responsibility to note your appointment day and time. We ask that you provide us with the best possible way to reach you (phone, text, email) and the corresponding number or address.

Thank you for your understanding and cooperation.

I understand and agree with this Scheduling Agreement.

_____

Person responsible for Account (Print)

_____ _____

Signature *Date*

FINANCIAL AGREEMENT

Thank you for choosing Concord Dental Care! Our primary mission is to deliver the best and most comprehensive dental care available.

Please note:

- Concord Dental Care requires payment the same day of treatment.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.
- Please remember that insurance reimbursement is *estimated* only and may not reflect what your insurance carrier will actually cover. In the event where we do not receive payment from your insurance carrier within 30 days, *you are responsible for full payment* of any treatment rendered.
- Concord Dental Care charges $50 for returned checks.

Payment Options:

- You may pay by cash, check or major credit/debit card
- You may apply for a line of credit for your dental treatment, such as Proceed Finance, CareCredit, or TheLending Club (credit inquiry required). We can let you know within a few minutes how much you qualify for using this payment option.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I understand and agree with this Financial Agreement.

_____

Person responsible for Account (Print)

_____ _____

Signature *Date*

ASSIGNMENT OF RIGHTS AND BENEFITS

Patient Name _____ Date of birth _____

Policy Holder's Name _____

Insurance Co. _____ Claim/Group No. _____

Employer _____

1. I hereby assign all rights and benefits under my insurance contract with _____
   Dental Insurance Company
   to Dr. Herrera for the purpose of determining the details of the benefits of this policy and obtaining payment for services given.
2. This assignment further permits Dr. Herrera to obtain from my insurance company all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Dr. Herrera of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.
3. This assignment shall allow Dr. Herrera to take all action necessary to obtain the benefits I have, in good faith, been promised by my insurance company.
4. All benefits are to be paid directly to: Concord Dental Care, G. Allen Herrera, DDS
   5167 Clayton Road, Ste. C, Concord, California 94521
5. If my current policy prohibits direct payment to Dr. Herrera, then I hereby also instruct and direct you to make out the check to me and mail it care of: Concord Dental Care, G. Allen Herrera, DDS
   5167 Clayton Road, Ste. C, Concord, California 94521
6. A photocopy of this assignment shall be considered as effective and valid as the original.
7. I further authorize Dr. Herrera to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.
8. This assignment shall remain in effect for the duration of treatment and any additional time necessary to secure full payment for services rendered.
9. This is a direct assignment of my rights and benefits under this policy.

The undersigned certifies that he/she has read and understands the foregoing, and accepts its terms.

_____ _____
Signature of Policy Holder *Date*

_____ _____
Signature of Patient (if other than Policy Holder) *Date*

Assignment means "to give." This form means you are giving this office full authorization to act on your behalf in obtaining information and collecting money for your health care at this office. **You are still responsible for the full balance of your care including deductibles, co-payments and any amounts your insurance company will not pay.**

Patient Acknowledgment of Receipt

The Facts About Fillings

Dental Materials Fact Sheet

☑ I acknowledge that I have received from G. Allen Herrera, D.D.S., Concord Dental Care, the Dental Materials Fact Sheet developed by the Dental Board of California.

☑ I understand that this fact sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations.

☑ I understand that I should review this information to make a fully informed decision regarding dental restorative treatment.

☑ I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with my dentist before undertaking any restorative treatment.

_____ _____

Patient / Guardian Signature *Date*

Patient Acknowledgment of Receipt
Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at ant time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient / Guardian Signature *Date*