

Welcome!



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 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:

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

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 _____

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 _____
 Epilepsy / 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
 Immunosuppression 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 **48-hours advance notice** if you must change, cancel or reschedule your appointment.

Please be advised that a change or cancellation with less than 48-hours notice of your scheduled appointment may result in a charge of \$50.00 per hour.

As a courtesy, we will try to contact you in advance to remind you of your appointment. We ask that you provide us with the best possible way to reach you (phone, text, email, etc.) 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 90 days, *you are responsible for full payment* of any treatment rendered.
- For our patients without the benefit of dental insurance, we offer a 10% courtesy accounting adjustment when paying by cash or check.
- Concord Dental Care charges \$25 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 dental work, such as CareCredit or TheLendingClub. 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, Suite 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, Suite 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 any 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