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

DENTAL INSURANCE

Who is responsible for this account?

Do you have dental insurance?

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 _____

HOW DID YOU HEAR OF US?

Source

Name _____

DENTAL HISTORY

Briefly list your 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? Describe _____

Do you feel nervous about having dental treatment? Describe _____

Have you ever had an upsetting dental experience? Describe _____

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

Sensitivity to sweet	Loose or broken teeth/fillings	Ear aches, neck pain	Lip or cheek biting
Sensitivity to hot	Burning sensation on tongue	Jaw pain or soreness	Difficulty opening/closing
Sensitivity to cold	Trapped food between teeth	Jaw clicking, popping	Dry mouth
Sensitivity to biting, 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 currently have:
Active Tuberculosis (TB)
Cough with blood
Persistent cough 3 weeks

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

AIDS/HIV
Allergies (hay fever, seasonal)
Alzheimer's Disease
Anemia
Angina (Chest pains)
Anorexia / Bulemia
Arteriosclerosis
Arthritis / Gout / Rheumatism
Artificial heart valves
Artificial joints (hip, knee, etc.)
Asthma
Blood Pressure
High Low
Blood transfusion
Bleeding (abnormal, irregular)
Bruising easily
Cancer, tumors, growths
Chemotherapy (cancer)
Chest pain upon exertion
Cholesterol
High Low
Chronic pain
Cold sores, herpes (lips)
Congenital heart defect
Coronary artery disease
Damaged heart valves
Diabetes, childhood or adult
A1C_____ Blood glucose_____
Epilepsy / Seizures
Excessive Thirst
Fainting spells / dizziness
GERD (Acid Reflux) / Heartburn
Glaucoma
Headaches / Migraines (frequent)
Heart arrhythmias (irreg. beat)
Heart attack
Heart disease (CHF)
Heart murmur
Hemophilia
Hepatitis / liver disease
Hypoglycemia
Immunosuppresion (Cortisone)
Jaw Pain / TMJ / TMD
Kidney problems
Mitral valve prolapse
Muscle pain / Fibromyalgia
Neurological disorders
Osteoporosis (Low Bone Density)
Pacemaker
Parathyroid problems
Psychiatric care
Radiation Treatments (cancer)
Recurrent infections
Respiratory Disease
Emphysema COPD
Restless Leg Syndrome / RLS
Rheumatic Fever
Sexually transmitted disease (STD)
Sinus Pressure, Aches
Sleep apnea / Nighttime breathing
Sores / ulcers in the mouth
Stomach / Intestinal disease
Stroke
Swollen neck glands
Systemic lupus erythematosus
Thyroid problems
Tonsilitis
Urination, excessive
Weight Loss (rapid unexplained)

1. Is your overall health good? Last medical check-up _____
2. Have you been hospitalized within the last three years? Why: _____
3. Do you need antibiotics before your dental visit? Why:_____
4. What medications or vitamins do you take now? _____
5. Do you smoke or chew tobacco? How often? _____ /day
6. Have you or do you currently use non-prescribed drugs?
7. Have you taken **bisphosphonates** (Fosamax, Boniva, Prolia) or diet drugs (Fen-phen, Redux)? _____
8. Have you ever had an **allergic or bad** 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? Are you Nursing?
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 _____

Concord
DENTAL CARE
G. Allen Herrera, D.D.S.

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 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*