Dental Care of Antioch

# PATIENT INFORMATION

**Patient Name:** ____________________________________________
(Last) (First) (Middle)

(Preferred Name) ______________________ Social Security # ________ - ______ - ________

Date of Birth: ________________ (If patient is a minor, give parent's/guardian's name): ____________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Phones: (______)______________ (______)______________ (______)______________
(Home) (Cell) (Work)

Address: ____________________________________________
(Number) (Street) (City) (Zip)

E-mail Address: ____________________________________________

**SPOUSE/PARTNER/Parent**

Last Name: ________________ First: ________________ Relationship: ________________

Phones: (______)______________ (______)______________ (______)______________
(Home) (Cell) (Work)

Emergency Contact: ________________ ________________ ________________
(Name) (Phone Number) (Relationship)

**EMPLOYER NAME:** ______________________________ Phone: (______)______________

Occupation: ______________________________

Address: ____________________________________________
(Number) (Street) (City) (Zip)

**PRIMARY INSURANCE COVERAGE**

Insurance Name: ______________________________ Phone: (______)______________

Group # ________________ Group Name: ______________________________

Subscriber Name: ______________________________ Subscriber DOB: ________________

Social Security #: ______________________ Relationship to Patient: ________________

**SECONDARY INSURANCE COVERAGE**

Insurance Name: ______________________________ Phone: (______)______________

Group # ________________ Group Name: ______________________________

Subscriber Name: ______________________________ Subscriber DOB: ________________

Social Security #: ______________________ Relationship to Patient: ________________

Whom may we thank for referring you? ______________________________

List family member(s) who are currently patients of this practice: ______________________________

Reason for today's visit / chief concern? ______________________________

**Patient / Guardian Signature:** ______________________ **Today's Date:** ________________

Dental Care of Antioch

# Office Policies & Consents

**• HIPPA**

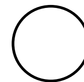
I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations by DCA. I have received the Notice of Privacy Practices before deciding to sign this Consent. This Notice provides a description of the uses and disclosures taken to my protected health information, and of other important matters about my protected health information.

I also have the right to revoke this Consent at any time by giving DCA written notice of revocation submitted to the office manager or treatment provider. (Note: Revocation of this Consent will not affect any action taken in reliance on this Consent before receiving the revocation, and that DCA may decline to give treatment or to continue treatment once this Consent is revoked.)

**• CONSENT FOR TREATMENT**

I hereby authorize DCA and/or designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by a doctor to make diagnosis.

I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient ______________________). I understand that using anesthetic agents entail certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.



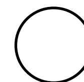
**• ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage indicated on the Patients Registration, and assign directly to Elika Mirzaagha/Dental Care of Antioch all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

DCA may also use my health information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**• DENTAL MATERIALS FACT SHEET**

I acknowledge that I have received the Dental Materials Fact Sheet developed by the Dental Board of California. I understand that this 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 the dentist.



**• I ACKNOWLEDGE UNDERSTANDING AND ACCEPTANCE OF THE FOLLOWING OFFICE POLICIES:**

**(24-Hour Cancellation Policy)** Each patient is required to provide advanced notice to allow DCA to arrange office schedules. Failure to notify any cancellation of appointments 24 hours in advance will result in a $40.00/hour fee. Two such incidents shall be considered as automatic noncompliance and withdrawal of dental treatment.

**(Returned Checks)** Will be subject to an additional charge of $40.00.

**(Payments)** Co-payments and/or Payments are due when Services are rendered. An estimate of your financial responsibilities shall be provided prior to or during your visit. If you did not receive an estimate, a copy shall be made immediately upon request.

**(Insurance Claims)** We must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. We have no authority over eligibility, benefits, fee schedules, or other membership entitlements. Thus as a courtesy, DCA will process insurance claims on your behalf, but you are still responsible for the payments of services rendered. Any claims outstanding after 30 days will be billed directly to you. Any unpaid balances after 60 days will be submitted to Collections.

**• (Information Update) Each patient is responsible for updating any changes to health, medication, insurance coverage, and/or personal information including work performed at other offices, contact information, job changes, etc.**

**I,** __________________________________________ **Patient/Guardian acknowledge understanding and acceptance of the above.**

(Print Name)

**Patient / Guardian Signature:** _________________________________ **Today's Date:** _____________