TEMPLE CITY
DENTAL CARE

Patient Acknowledgements and Authorizations

Patient Name: _____ **Date**: _____

Welcome! At *Temple City Dental Care*, we are committed to providing you with the best possible dental care and helping you achieve your optimum oral health. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available to provide you quality dental care.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Towards these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Your Commitment (*Patient Responsibilities*)

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance-related questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, and the following credit cards – American Express, Master Card, Discover, and Visa. We also offer third-party financing, which includes both interest-free programs and extended financing. *Note*: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a *Credit for Dental Services Notice*.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you and your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

We kindly ask that you realize we do NOT work for an insurance company. Rather, we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT YOUR INSURANCE COVERAGE.

- **If we are a contracted provider with your plan**, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

- **If we are not a contracted provider with your dental benefit plan**, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

TEMPLE CITY
DENTAL CARE

Scheduling of Appointments: We reserve the doctor and the hygienist's time on the schedule exclusively for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. We understand that circumstances may arise that require an appointment to be rescheduled; however, to maintain the utmost service and care, we do require a 48-hour notice to reschedule an appointment. **With less than a 48-hour notice, a fee of $50.00, or deposit to reserve the appointment time again, may be required.** To serve all our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50 or deposit to reserve the next appointment, may be required.

Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with the personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your reservation time if a 48 hour notice is given. If sufficient notice is not given, your account will be charged a $50 broken/missed appointment fee. We ask that you make every effort to keep your reserved time.

Patient Authorization

_____ I understand that the information I have given today is correct to the best of my knowledge. I authorize the dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment.

_____ I have read the above and agree to the financial and scheduling terms.

_____ I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.
Please check Yes or No, and initial to the side. ____ **YES** ____ **NO**

Patient Communications

_____ **Messages**: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication.

Email: Except for appointment reminders, we use secure methods to electronically communicate with our patients. Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum amount of protected health information in any communication. **Please select one of the following three (3) options, initial, and provide your email address**.

_____ 1) I ***do*** consent and accept the risk of receiving information via unsecured email. I understand I can withdraw my consent at any time.
My email address is: _____

_____ 2) I ***do*** consent to receive *appointment reminders only* via unsecured email. I understand I can request an alternate method of appointment reminders at any time.
My email address is: _____

_____ 3) I ***do not*** consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Mobile Phone:

_____ I ***do*** consent to the dental practice using my mobile phone number to (Please choose one or both) ____ ***call*** or ____ ***text*** regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cellphone number is (include area code)

_____ I ***do not*** consent to the dental practice using my mobile phone number to either call or text. I understand that I can change my mind and provide consent later.

TEMPLE CITY
DENTAL CARE

Patient Acknowledgements

_____ I hereby acknowledge that a copy of this practice's ***Notice of Privacy Practices*** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____
Type or Print Patient's or Legal Guardian's/Representative's Name

_____ _____ _____
Patient or Legal Guardian's/Representative's Signature Relationship (if not patient) Date

Kyle Low, DDS
9929 E. Las Tunas Drive, Temple City, CA 91780
626-285-3161 Fax: 626-285-5379
www.templecitydental.com

TEMPLE CITY
DENTAL CARE

The Pathway to Dental Excellence!

ABOUT YOU

Patient Name: _____ Date: _____

I Prefer to be called: _____ ○ Male ○ Female

Birthdate: _____ Age: _____ ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Home Address _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Mobile: _____ Work Phone: _____

Email address: _____

Best time to reach you? _____ How did you hear about us? _____

Social Security # _____ Driver License/ID# _____

Person to contact in case of emergency: _____ Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____
STREET CITY STATE ZIP CODE

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relation: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP CODE

Treatment and Arbitration Agreement

With regard to dental care and services provided or to be provided at Temple City Dental Care, it is agreed that the attending dentist will provide dental care and services to the patient, to the best of their skills and knowledge which dental care in the light of circumstances is possible and practical. It is agreed that because of differences in human constitution and response, it is no way possible to warrant the outcome of any medical or dental service.

It is understood that any dispute as to dental malpractice, that is as to whether any dental service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceeding. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Within fifteen days after a Patient or Attending Dentist shall give notice to the other demanding arbitration of such controversy, the parties to the controversy shall each appoint a licensed dentist as arbitrator and give notice of such appointment to the other. Within a reasonable time to two arbitrators shall select a licensed dentist as neutral arbitrator and give notice to the selection there of to the parties. The arbitrators shall hold a hearing within a reasonable time. All notices or other paper required to be served by United States mail. The arbitration shall be conducted in accordance with any government by the provision of Title 9 of the California Code of Civil Procedure.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____ _____
Patient / Guardian Signature Date Relationship

_____ _____
Attending Dentist Signature Date Witness Date

TEMPLE CITY
DENTAL CARE

ABOUT YOUR INSURANCE INFORMATION

The Pathway to Dental Excellence!

Primary Insurance

Dental Coverage? ◯ Yes ◯ No Orthodontic Coverage? ◯ Yes ◯ No Medical Coverage? ◯ Yes ◯ No

Insurance Name: _____ Phone: _____

Group #: Member ID #:

Ins. Co. Address: _____
STREET CITY STATE ZIP CODE

Insured's Name: _____ Insured's SSN: _____ DOB: _____

Insured's Employer: _____ Relationship to Patient: _____

Employer' Address: _____
STREET CITY STATE ZIP CODE

Employer's Phone: _____

Dental Coverage? ◯ Yes ◯ No Orthodontic Coverage? ◯ Yes ◯ No Medical Coverage? ◯ Yes ◯ No

Insurance Name: _____ Phone: _____

Group # _____ Member ID #:

Ins. Co. Address:
STREET CITY STATE ZIP CODE

Insured's Name: _____ Insured's SSN: _____ DOB: _____

Insured's Employer: _____ Relationship to Patient: _____

Employer' Address: _____
STREET CITY STATE ZIP CODE

Employer's Phone: _____

Assignment of Insurance Benefits

I hereby authorize Temple City Dental Care to furnish information to insurance carriers concerning treatment and hereby assign to the doctors all payments for dental services rendered. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by said Insurance/Dental Plan. I hereby authorize said assignee to release all information necessary to secure payment.

I authorize Kyle Low, DDS, or the attending dentist to examine and provide medical/dental treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Kyle Low, DDS. I authorize the release of any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments, specialists, and specialist providers which are assigned to me according to my insurance policy rule. It is Kyle Low, DDS's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____ _____
Patient / Guardian Signature Date Relationship

_____ _____ _____ _____
Attending Dentist Signature Date Witness Date

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____ Date of most recent x-rays _____ _____ _____
Date of most recent treatment (other than a cleaning) _____ _____ _____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you get food caught between any teeth? _____ ☐ ☐

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Temple City Dental Care

HIPAA Privacy Rule: Acknowledgement of Receipt of Notice of Privacy Practices §164.520(a)

I, _____ (*Please Print Full Name*), understand that as part of my health care, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I hereby acknowledge that I have been provided with and understand that this facility's *Notice of Privacy Practices* provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgement
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested.

Patient or Personal Representative:

Name:_____
(*Please Print Full Name*)

Signature: _____ Date: _____
(*Please Sign*)

Relationship (*if <u>not</u> patient*) (e.g. mother, father): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign (Date of Refusal: ___/___/_____)
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

Attempt was made by: _____ Date: _____