ALL CARE DENTAL

3200 Mowry Avenue | Suite A, Fremont, CA 94538

Phone: (510) 648-2487
Fax: (510) 894-2597
Email: info@allcaredentalca.com
www.allcaredentalca.com

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Information

Patient Name:_____ _____ _____ _____
Last Name *First Name* *MI* *Preferred Name*

Title: (Mr./Mrs./Ms)_____ Gender: ❍ Male ❍ Female Family Status: ❍ Married ❍ Single ❍ Child ❍ Other

Birth Date: _____ Social Security #_____ Previous Visit:_____

Email: _____ Best Time to Call: _____

Home Phone:_____ Cell:_____ Work: _____ Ext. _____

Fax: _____ Other:_____

Primary Address: _____

City:_____ State:_____ Zip:_____

Address 2:_____

City:_____ State:_____ Zip:_____

Employer:_____ Address:_____

Emergency Contact:_____ Phone: _____ Cell: _____

Relationship to the Patient:_____ Referred by:_____

Spouse or Responsible Party

The following is for: ❍ Patient's Spouse ❍ Person responsible for Payment ❍ Both ❍ Neither Not Applicable

Name:_____ _____ _____ _____
Last Name *First Name* *MI* *Preferred Name*

Title: (Mr./Mrs./Ms)_____ Gender: ❍ Male ❍ Female Family Status: ❍ Married ❍ Single ❍ Child ❍ Other

Birth Date: _____ Email Address:_____ Best Time to Call: _____

Home Phone:_____ Cell:_____ Work: _____ Ext. _____

Primary Address:_____ Address 2#_____

City:_____ State:_____ Zip:_____

Employment Information

The following is for ❍ the patient ❍ the person responsible for payment ❍ both ❍ Not applicable

Employer Name:_____ Phone:_____

Address:_____ Address 2: _____

City:_____ State:_____ Zip:_____

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Primary Dental Insurance Information

Patient's Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Name of Insured:_____ _____ _____
Last Name *First Name* *MI*

Insured Date of Birth:_____ ID#:_____ Group #:_____

Insured's Address:_____ City:_____ State:_____ Zip:_____

Insured's Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Insurance Plan Name:_____

Insurance Address: _____ City:_____ State:_____ Zip:_____

Primary Medical Insurance Information

Patient's Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Name of Insured:_____ _____ _____
Last Name *First Name* *MI*

Insurance Plan Name:_____

Name of Insured:_____ _____ _____
Last Name *First Name* *MI*

Insured Date of Birth:_____ ID#:_____ Group #:_____

Insured's Address:_____ City:_____ State:_____ Zip:_____

Insured's Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Patient's Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insurance Plan Name:_____

Insurance Address: _____ Address 2:_____

City:_____ State:_____ Zip:_____

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Patient Acknowledgment
Recipient of the California Dental Fact Sheet

❑ By checking this box, I certify that I have read the Fact Sheet describing the risks and benefits of dental restorative materials. I have also had an opportunity to discuss and ask questions regarding the information contained in this material fact sheet with my treating dentist and/or a member of the dental team.

Acknowledgment of receipt of Notice of Privacy Practices
"You may refuse to sign this Acknowledgment"

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives the authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

_____

_____

Consent for Examination, X-Ray Diagnostic Series, Insurance Authorization/Pre-Estimates:

To my knowledge, the information contained in this form is correct to date. I authorize this practice to take diagnostic x-rays, models, photographs or other records to be used in the diagnosis and treatment of conditions found. I have received the notice of privacy practices required by HIPAA. I am informed and aware that I have the right to read the "Notice of Privacy Practices" before giving consent to use or disclose personal information to third party reimbursement, nancing or other payment arrangement organizations.

I understand that I am solely responsible for any and all fees incurred in my treatment. I am aware that this practice will assist me in providing specific information to third party reimbursement and/or insurer organizations with my authorization to do so.

❑ By checking this box, I understand the above information and agree with its contents and this will serve as my signature for the HIPAA Disclosure Form.

Name of the Person Completing the Form (Please print):_____

Signature:_____ Date: _____/_____/_____

Dr./Staff Signature:_____ Date: _____/_____/_____

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Patient Health HIstory

Patient Name:_____ _____ _____ _____
Last Name *First Name* *MI* *Preferred Name*

Height:_____ Weight: _____

Please indicate any of the following conditions that you have had or presently have:

- ❑ *Pre-Med - Amoxicillin
- ❑ Allergy - Aspirin
- ❑ Allergy - Latex
- ❑ Anemia
- ❑ Blood Disease
- ❑ Epilepsy
- ❑ Head Injuries
- ❑ High Blood Pressure
- ❑ Liver Disease
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Veneral Disease
- ❑ *Pre-Med - Clindamycin
- ❑ Allergy - Codeine
- ❑ Allergy - Other _____
- ❑ Arthritis
- ❑ Cancer
- ❑ Excessive Bleeding
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Mental Disorders
- ❑ Pregnancy
- ❑ Rheumatism
- ❑ Tuberculosis
- ❑ *Pre-Med - Other _____
- ❑ Allergy - Ethromycin
- ❑ Allergy - Penicillin
- ❑ Artificial Joints
- ❑ Diabetes
- ❑ Fainting
- ❑ Heart Murmur
- ❑ Jaundice
- ❑ Liver Disease
- ❑ Nervous Disorders
- ❑ Radiation Treatment
- ❑ Sinus Problems
- ❑ Tumors
- ❑ Allergies
- ❑ Allergy - Hay Fever
- ❑ Allergy - Sulpha
- ❑ Asthma
- ❑ Dizziness
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Other _____
- ❑ Respiratory Problems
- ❑ Stomach Problems
- ❑ Ulcers

❑ Yes ❑ No Active Tuberculosis
❑ Yes ❑ No Persistent cough greater than 3 week duration?
❑ Yes ❑ No Been exposed to anyone with Tuberculosis?
❑ Yes ❑ No Cough that produces blood

DENTAL INFORMATION

❑ Yes ❑ No Do your gums bleed when you brush or floss?
❑ Yes ❑ No Are your teeth sensitive to cold, hot, sweets or pressure?
❑ Yes ❑ No Is your mouth dry?
❑ Yes ❑ No Have you had periodontal (gums) treatment?
❑ Yes ❑ No Have you ever had orthodontic (braces) treatment
❑ Yes ❑ No Have you ever had problems associated with previous dental treatment?
❑ Yes ❑ No Is your home water supply fluoridated?
❑ Yes ❑ No Do you drink bottled or filtered water? If yes, how often? ❑ Daily ❑ Weekly ❑ Occasionally
❑ Yes ❑ No Are you currently experiencing dental pain or discomfort?
❑ Yes ❑ No Do you have earaches or neck pain?
❑ Yes ❑ No Do you have any clicking, popping or discomfort in the jaw?
❑ Yes ❑ No Do you brux or grind your teeth?
❑ Yes ❑ No Do you have sores or ulcers in your mouth?
❑ Yes ❑ No Do you wear dentures or partials?
❑ Yes ❑ No Do you participate in active recreational activities?
❑ Yes ❑ No Have you ever had a serious injury to your head or mouth?

Date of your last dental exam?_____/_____/_____

What was done at that time?_____

_____

Date of last dental xrays? _____/_____/_____

What is the reason for your visit today?_____

_____

How do you feel about your smile?_____

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Medical Information

Are you now under the care of a physician? ❑ Yes ❑ No Physician's Name:_____
Address:_____ City:_____ State: _____ Zip:_____
Are you in good health? ❑ Yes ❑ No Has there been any changes in your general health within the past year? ❑ Yes ❑ No
If yes, what condition is being treated? _____
_____
Date of last physical exam: _____/_____/_____
Have you had a serious illness, operation or been hospitalized in the last 5 years? ❑ Yes ❑ No
If yes, what was the illness or problem? _____
_____
Are you taking or have you recently taken any prescription or over the counter medicine? ❑ Yes ❑ No
List all over the counter and prescription medications, vitamins, natural or herbal preparations, and/or dietary supplements.
_____
_____
_____
Do you wear contact lenses? ❑ Yes ❑ No
Have you had orthopedic joint (hip, knee, elbow, finger) replacement? ❑ Yes ❑ No If yes, what was the date? ___/___/___
Did you have any complications?_____

Are you taking or have you ever taken either of the medications Alendronate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's Disease? ❑ Yes ❑ No

Are you taking or have you ever taken Phen-fen (Fenfluramine-phenterine combintation)? ❑ Yes ❑ No

Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma, or metastatic cancer? ❑ Yes ❑ No Date treatment began: ___/___/___
_____
_____

Do you use controlled substances? ❑ Yes ❑ No Do you use tobacco (smoking, snuff, chew, bidis)? ❑ Yes ❑ No
If yes, how interested are you in stopping? ❑ Very Interested ❑ Somewhat Interested ❑ Not Interested
Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink each week? ❑ 1-3 drinks/week ❑ 4-7 drinks/week ❑ More than 7 drinks/week

Women Only

Are you pregnant? ❑ Yes ❑ No If yes, how many weeks? _____ Are you currently nursing? ❑ Yes ❑ No
Are you taking birth control pills or hormone replacement? ❑ Yes ❑ No

Allergies

Are you allergic to or have you had a reaction to:

❑ Yes ❑ No Aspirin
❑ Yes ❑ No Local Anesthetics
❑ Yes ❑ No Penicillin or other Antibiotics
❑ Yes ❑ No Barbiturates, sedatives, or sleeping pills
❑ Yes ❑ No Sulfa drugs
❑ Yes ❑ No Codeine or other narcotics
❑ Yes ❑ No Metals
❑ Yes ❑ No Latex (Rubber)
❑ Yes ❑ No Iodine
❑ Yes ❑ No Hay Fever / Seasonal
❑ Yes ❑ No Animals
❑ Yes ❑ No Food
❑ Yes ❑ No Other

If you checked yes to any of the above items, please specify the type of reaction:_____
_____
_____
_____

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Please indicate any of the following conditions that you have had in the past or presently have:

❑ Yes ❑ No Artificial (Prosthetic) heart valve
❑ Yes ❑ No Previous infective endocarditis
❑ Yes ❑ No Damaged valves in transplanted heart
❑ Yes ❑ No Unrepaired, cyanotic Congenital heart disease
❑ Yes ❑ No Repaired CHD (completely) in last 6 months
❑ Yes ❑ No Repaired CHD with residual defect

Note: Except for conditions listed above, antibiotic prohpylaxis is no longer recommended for any other form of CHD.

Please indicate any of the following conditions that you have had in the past or presently have:

❑ Yes ❑ No Cardiovascular Disease
❑ Yes ❑ No Angina
❑ Yes ❑ No Arterioscierosis
❑ Yes ❑ No Congestive Heart Failure
❑ Yes ❑ No Damaged Heart Valve
❑ Yes ❑ No Heart Attack
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No Other Congenital Heart Defects
❑ Yes ❑ No Mitral Valve Prolapse
❑ Yes ❑ No Pacemaker
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Rheumatic Heart Disease
❑ Yes ❑ No Abnormal Bleeding
❑ Yes ❑ No Blood Transfusion When_____/_____/_____
❑ Yes ❑ No Hemophilla
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Autoimmune Disease
❑ Yes ❑ No Rheumatoid Arthritis
❑ Yes ❑ No Systemic Lupus Erythematosus
❑ Yes ❑ No Asthma
❑ Yes ❑ No Bronchitis
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Sinus Trouble
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Cancer/Chemotherapy/Radiation Treatment
❑ Yes ❑ No Chest Pain Upon Exertion
❑ Yes ❑ No Chronic Pain
❑ Yes ❑ No Diabetes Type I or II
❑ Yes ❑ No Eating Disorder
❑ Yes ❑ No Malnutrition
❑ Yes ❑ No Gastrointestinal Disease
❑ Yes ❑ No GE Reflux/Persistant Heartburn
❑ Yes ❑ No Ulcers
❑ Yes ❑ No Thyroid Problems
❑ Yes ❑ No Stroke
❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Hepatitis, Jaundice or Liver Disease
❑ Yes ❑ No Epilepsy
❑ Yes ❑ No Fainting Spells or Seizures
❑ Yes ❑ No Neurologica Disorders
If yes, explain:_____
_____
_____
❑ Yes ❑ No Sleep Disorder
❑ Yes ❑ No Snoring
❑ Yes ❑ No Mental Health Disorder
If yes, explain:_____
_____
_____
❑ Yes ❑ No Recurrent Infections
If yes, explain:_____
_____
_____
❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Night Sweats
❑ Yes ❑ No Osteoporosis
❑ Yes ❑ No Persistent Swollen Glands in Neck
❑ Yes ❑ No Severe Headaches/Migraines
❑ Yes ❑ No Severe or Rapid Weight Loss
❑ Yes ❑ No Sexually Transmitted Disease
❑ Yes ❑ No Excessive Urination

❑ Yes ❑ No Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Doctor or Dentist Name:_____ Phone: _____
Please list any diseases, conditions or problems not listed above that you think I should know about:_____
_____
_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

Emergency Contact Name:_____ Phone: _____
Relationship to the Patient: _____

❑ **By checking this box, I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other members of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

Name of the Person Completing the Form (Please print):_____

Patient Signature:_____ Date: _____/_____/_____

Dr. Signature:_____ Date: _____/_____/_____

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Financial Agreement

Patient Name:_____ _____ _____ _____

Last Name *First Name* *MI* *Preferred Name*

As a courtesy, we assist you in billing your insurance if you choose to use insurance benefits to pay for dental treatment. However, we are limited to billing services rendered and possibly, assign payment to us. Insurance benefits and fees are agreed upon by you and your insurance company. The insurance pays for your benefits based on a fee schedule. Therefore, you are responsible for the following:

- Any portion not paid by insurance. Treatment fees are based on insurance ESTIMATES only.
- Deductibles and co-payments due on the day services are rendered.
- Keeping track of maximum benefits allowed and remaining.
- Any treatment unpaid by the insurance. Some treatment may not be covered by your insurance plan. If you have questions about your coverage, please call the insurance company and as a subscriber, they can give you all the information you need.

If you are not using insurance benefits to pay your dental treatment, we can assist you with a third party payment plan such as Care Credit, based on treatment recommended by the doctor. Treatment fees are ESTIMATES only, The fee may change if you or your child's dental needs change. We will inform you of the charges beforehand.

A late notice though will result in a cancellation fee. We gladly accept checks and should the bank return it unpaid, there is a $35.00 fee. We will require subsequent payments in cash, cashier's check, money order or debit/credit card.

❑ By checking this box, I am authorizing Anil Chowdhary DMD Inc./All Care Dental and their constituents to obtain insurance information and to bill my insurance for services. I have read and understood the forgoing policies.

Name of the Person Completing the Form (Please print):_____

Signature:_____ Date: _____/_____/_____

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Office Policy

Dear Patients:

We appreciate the opportunity to serve your dental health needs. Our goal is to provide the best care possible for our patients. We want to give you the opportunity to enjoy optimal dental health throughout your life. This statement has been prepared to give you some information about our office policies. Please ask the front desk staff if you have any questions about the information covered in this statement.

Estimates:

Before we begin treatment, we will provide you with a complete ideal diagnosis. Based on the information we will give you an estimate of the total cost of your treatment. As we proceed with this treatment, we may encounter additional problems or circumstance that may not have been apparent at the time of the initial examination. In this event, we will make every effort to fully discuss the problem with you, including the effect, if any, it may have on your financial obligation,

Down Payments:

We request that professional services be paid for at the time of the appointment unless arrangements have been made. We offer payment options below, with valid ID.

- Cash
- VISA
- Discover
- Master Card
- Checks

Patients paying in cash in advance of treatment may be eligible for a discount. Please ask our Office Manager for more details.

Broken Appointments:

We require a minimum of 48 hours notification in the event you are unable to keep your scheduled appointment. As long as this notice is received, there will be absolutely no charge for canceled or rescheduled appointment. However, if you fail to provide us with this notice during regular business hours, you account will be subject to a $50.00 charge.

Patients with Dental Insurance:

We will provide as much assistance as possible with insurance eligibility, coverage, and exclusions; however, the patient assumes full responsibility for the understanding of their policy's limitations and provisions. In th event of an eligibility concern, please contact your dental insurance plan to confirm that you are eligible to receive treatment at our office. We will require payment of the portion of the charges that your insurance company will not cover, including all deductibles and estimated co-payments at the time services are rendered.

PPO (Preferred Provider Organization) - Most common form of Insurance

It is our policy to receive full payment at the time services are rendered, for your convenience, we accept cash, checks and most major credit cards. We also have a monthly payment plan available to those who qualify. Responsibility for treatment or a minor is the adult parent or guardian accompanying the child. We do not bill services to the unaccompanied minor.

Accounting Concerns / Delinquent Accounts:

We will make every attempt to assist you with questions regarding your account and billing concerns, in the event that an account is deemed delinquent, outside collection action may be taken and the responsible party for the account is liable for all reasonable attorney's fees and collection costs.

❑ By checking this box, I understand the above information and agree with its contents of this Administration form.

Patient Name:_____ _____ _____ _____

Last Name *First Name* *MI* *Preferred Name*

Name of the Person Completing the Form (Please print):_____

Signature:_____ Date: _____/_____/_____

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the _____ All Care Dental/ Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____