EMERYVILLE DENTAL CARE www.EmeryvilleDental.com

6001 Shellmound St Ste 125 Emeryville, CA 94608 Phone: (510)595-1900 Fax: (510)594-8900 NP 9.23.10

WELCOME to our Office! *Thank you for joining us! We hope you bring the rest of your family, friends, and co-workers here as well. We would like to fulfill your dental needs for the rest of your life. Your overall dental health is our concern. ASK what YOU DESERVE! We want you to be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary.*

Today's Date: / / **PERSONAL INFORMATION:** (*Please complete fully. All information will be held in strict confidence.*)

Patient's Full Name:_____What name do you wish to be called?_____

Patient's Address:_____Apt #_____City:_____ State: _____ Zip:_____

Email Address:_____@_____Home Phone # ( )_____-_____ **Cell** # ( )_____-_____

Patient's Birthdate:_____/_____/_____ Age:_____ Social Security #:_____-_____-_____ Driver's License #:_____**(ID's required)**

(Circle that applies): Male Female Married Single Divorced Partnered Separated Widowed Engaged: Wedding date ____/____/____

Spouse's Name:_____or Significant Other's Name:_____Children's Names(& Ages):_____

Patient's Employer:_____Address:_____City:_____State:_____ Zip:_____

Work # ( )_____-_____ Occupation:_____Years:_____Fax # ( )_____-_____ Email Address:_____@_____

In Case of Emergency: Person to contact:_____Relationship:_____Home #( )_____-_____Work #( )_____-_____

Parents' Names & Address: _____ Phone # ( )_____-_____

Closest Relative's not living with you. Name/Relationship/Address/Phone#'s:

(The Parent who brings their child is the responsible party.)

If Patient is a Minor: Parent's Names:_____ Person Responsible (You) for Patient's Account: _____

Responsible Party's Social Security #_____-_____-_____ Driver's License#:_____ Birthdate:_____/_____/_____

Responsible Party's Address (if different from Patient):_____City: _____State: _____Zip: _____

Responsible Party's Home #( )_____-_____Work #( )_____-_____ Pager #( )_____-_____ Cell #( )_____-_____

Bring Out the Best in Yourself. You Deserve It!... We Want to Keep You Smiling….Because You Deserve It!

Whom can we Thank for Referring you to our Office:_____ Patients you will refer here:_____Best Appt Times/Days:_____

What would you like us to do for you today (main concern)? _____

What else would you like to share with the Doctor about your care/and or needs? _____

When was your: Last Complete Dental Exam?_____ Last Complete Dental (18) X-rays?_____ Last Cleaning?_____ Last Deep Cleaning?_____

Why did you leave your last dentist/dental office?_____

What did you like MOST about any dentist you've ever seen? _____ LEAST? _____

Describe the type of Dental treatment you deserve?

Write in "Yes" if you have any of the following: Pain upon chewing?_____ TMJ/jaw joint noises/pop/click?_____ Headaches upon waking up in the morning?_____ Sinus problems that happen at the same time as your toothache?_____ Facial Pain or Tic?_____ Constant numbing in or around face?_____ Jaw/ Teeth feel like it is not chewing or coming together properly?_____ Moving toothache?_____ Bad breath?_____ Other:_____

Previous dental work that is still a problem?_____

Your teeth are one of your most important assets. It can effect your self esteem, potential job offerings, potential mate selection and vice versa, & interactions with other people. It effects how you eat, bite, chew, talk, play wind instruments, sing, smile, sleep, overall health, and daily life.

Do you like your smile? Yes No Are you self-confident about smiling? Yes No Do you photograph better from one side of your face? Yes No

Do you ever put your hand over your mouth when you smile? Yes No Describe: Do you wish your teeth were whiter? Yes No

Do you wish you had fresher breath? Yes No Do you wish you had less bleeding gums? Yes No or Less sensitive gums? Yes No

Are you satisfied with the way your gums look? Yes No Do you show too many teeth when you smile?_____ or too few teeth when you smile? Yes No

Do you show too much or too little gum when you smile?_____ Are your teeth too long or too short? _____

Are your teeth too wide or too narrow?_____ Are your teeth too square or too round?_____ Are your teeth worn out/flat? Yes No

If we can show you an EASY and SAFE way to lighten your teeth/ brighten your smile, would you be interested? Yes No

If you could wave a magic wand and change your teeth or smile, what would you change?

Today's dentistry has made great advances. Dr Rose Magno can straighten your upper or lower teeth, fix your bite, design your smile, close your gaps, fill spaces between your teeth, change the shape of your tooth/teeth, reshape your gums, or lighten your teeth. Each process takes about 2 to 4 visits. If you are interested, ASK. Any other concerns? ASK. We CAN fix what you broke or neglected. We CAN enhance your smile & have you chew better. We can make you look years younger & feel more comfortable about your smile, if you want.Just ASK. We CAN help you accomplish these goals.Just Because...You Deserve it!

DENTAL INSURANCE INFORMATION:

Name of Dental Insurance Company:_____Phone #:1-(800 888 877 866)- _____-_____ Group #:_____

Insurance Claim Address:_____City:_____ State:_____ Zip:_____Effective Date:_____/____/_____

Insured's Name (if not the Patient):_____Insured's Social Security #:_____-_____-_____ Insured's Birthdate:____/_____/____

Insured's Employer's Name & Address:_____ How is the Patient related to the Insured? Self Spouse Child Other:_____

Do you have another dental insurance?_____ If Yes, then Who is the insured?_____Name of Insurance Company?_____

Insurance Phone #( ) - Insured's Social Security #: - - Insured's Birthdate: / / Relation to the Patient?

As a one time courtesy, we will bill your insurance for you. However, it is YOUR responsibility to make sure your Insurance (INS) company pays the remainder of your balance due in full within 30 day from your treatment date. Any remaining balances after 30 days will incur a 1.8% monthly finance charge and a $15 monthly billing/rebilling charge. It is your responsibility to know the remaining balance due after 30 days. Any request to resubmit your insurance claim (resubmissions) will result in a $10 charge per claim. (You have a right to be reimbursed by your insurance company for these charges. Call the State Insurance Commissioner or the Dept of Managed Care (for Delta members) for more details.)

Name: *Signature:* *Date:* / /

Patient's Agreement with Emeryville Dental Care (EDC)

Initials **PATIENT'S INFORMED CONSENT or If patient is a minor, PARENT'S or GUARDIAN'S INFORMED CONSENT** **9.25.12**

_____ **Consent to Dental Treatment:** **EDC**= Emeryville Dental Care

I, _____, authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the Patient's dental needs, medication, and therapy, that may be indicated in connection with (Patient's Name) _____and further authorized and consent that the Doctor choose and employ such assistance as deemed fit.

I understand the use of anesthetic agents embodies a certain risk (such as temporary or permanent numbing and numbing in other areas other than the tooth or gums being worked on).

I understand that decays or cavities may be deeper in actuality than is seen of x-rays and the Dentist may need to do further additional treatment such as but not limited to; pulp capping, larger filling, build up, gingivectomy, crown lengthening, root canal, post, crowns, bridges, extractions, implants, partials, dentures, bone grafts, gum grafts, gum surgery, recontouring or reshaping of gum and or bone, alveolarplasty, and or any other additional dental treatment which may need to be referred to a specialist. I understand that these and any other additional treatment(s) would be at an additional cost to me.

I understand that suggested treatment plans and alternatives will be explained and described to me with their risks (such as tooth mobility, tooth loss, tooth sensitivity to hot and cold temporarily or permanently that was not present before treatment) and benefits.

I understand Emeryville Dental Care (EDC) will inform me of my estimated treatment plan with it's estimated cost.

I understand that with regular professional checkups/exams (every 6 months) and cleaning, Emeryville Dental Care can provide early warning for breakdown of restorations which can result in less expensive treatment, less pain, and may minimize the need for future dental work.

I understand the longevity of any dental treatment lies mainly with the Patient who properly takes care of & maintains it with regular proper brushing (after every meal or 3 times a day, whichever is more), proper flossing (after every meal), proper diet, follows maintenance instructions given after treatment is completed, & Genetics.

_____ **Crowns, Bridges, Bleach, Veneers, Partials, and Dentures:**

I understand that these procedures take at least 2 appointments. If I do not come back for my subsequent appointments to have these delivered (bonded/cemented/put on) within one month, these may not fit and Emeryville Dental Care will charge me to redo/ remake another. If I do not come back to have these delivered, Emeryville Dental Care will only refund me 10% of the total fee because 90% of the work has already been completed.

I understand that if I lose my first/original temporary crown, a second can be remade at an additional cost to me.

_____ **Financial:**

I understand the responsibility for payment for dental services provided in this office for myself or my dependents is mine, and is due and payable at the time services are rendered. This means my dependents and I will need to pay for my (our) dental treatment that same day of service. I agree to have up to 1 year from service date (date of service) to claim or dispute EDC's billing or services rendered.

I further understand that finance charges (1.8% per month) and a $15 monthly billing charge will be added to any balance over 30 days from treatment date, regardless of insurance status, since Emeryville Dental Care has no control over my insurance policies, inclusions, and limitations.

I understand that Doctor's recommended treatment plan with it's associated cost for each procedure are only estimates until it's completion/completed.

I understand it is my responsibility to make sure I know how much treatment will cost for treatment that will be completed at the time of service and it is my responsibility to make sure I know how much treatment will cost for subsequent appointments.

I understand that changes to the treatment plan and it's associated fees can be caused by further treatment (described above) due to larger cavities or cavities not seen on x- rays, but is seen clinically. I understand if changes result because of a different treatment rendered, then there will be a change in the cost of the treatment. If I choose to continue treatment after the Doctor explains the change (s) in my treatment plan during my dental treatment or procedure, then it will be assumed that I have agreed to the new treatment and the added cost.

I understand that if I am referred to a specialist for any reason, their charges are at an additional cost to me and are not part of this office charges.

If initiated by my request, I understand there is a minimum charge of $50 as a research fee for obtaining or inquiring about my (each) account information over 6 months old and for obtaining or inquiring about my (each) account under collections status.

_____ I understand that in the event of default, I promise to pay your blemish processing fee (minimum $50), a blemish cost, research fees/ cost & other fees related to collecting my debt. In addition to these fees, additional fees will be added to my outstanding debt; a collection processing fee (minimum $50,plus an in-house collection cost of ½ (one half) the total amount due, which may be turned over to your collection agency or to the court system for collection, and I will be responsible for any legal fees incurred, copy costs (at 50 cents per page), mailing costs, & interest on the indebtedness, plus other costs, and reasonable attorney fees, as may be required to effect collection of this note.

_____ I authorize you to release my (patient's) information to my insurance company, any credit reporting agency, collection agency, or any other persons arising from or pertaining to collecting my debt. This is my HIPAA compliant medical records/billing release consent.

_____ If a dispute of a contractual nature arises between EDC and the I (the patient) and/or the patient's parent(s) and/or guardian regarding EDC's entitlement to fees and/or costs under this agreement, or the enforceability of any term of this agreement, EDC, if it prevails, shall be entitled to its attorney's fees and costs from patient and/or the patient's parent and/or guardian in enforcing the terms of this agreement. This provision also applies to EDC's seeking any monies for quantum meruit recovery for the reasonable value of the services and costs expended or incurred on behalf of the patient and/or the patient's parent and/or guardian. This provision expressly does not apply to any tort disputes between the parties including, but not limited to, claims in the nature of professional malpractice or statutory violations.

_____ **Insured Patients (& Patients thinking about being insured):**

I understand that it is my responsibility to review my dental booklet supplied to me by my employer, to supply this office with my correct insurance information, special clauses and services not covered by my insurance company in order for this office to ensure billing my insurance properly and give me an estimated cost for treatment recommended to me by the dentist.

I understand my Employer & My Insurance Company have made an agreement or a contract with each other and not with my dentist (or this dental office) to cover only a certain portion and/ or a certain percentage of my dental treatment. I understand the uncovered portion is my responsibility.

I understand that this dental office is not a contracted provider, not a member, nor is it owned by any insurance companies; which means this office is not limited to and is not subject to my insurance's rules & limitations. I understand that because of this, this office feels that they are committed more to what I need rather than be constrained to what my insurance company wants or dictates.

I understand that Emeryville Dental Care will help bill my insurance as a one time courtesy for me and/or my dependents or I may bill my own insurance.

I understand that this office helps keep track of & assists in ensuring that my insurance receives & pays for my dental claims (either by fax, by mail, electronically,&/or by phone). I give permission to transmit my name, birthdate, dental treatment and other pertinent information in order for my dental claims to be paid.

I understand that after 30 days from my treatment date, the remaining balance will be due in full, regardless (example: pending or disputed) of my insurance status.

I understand my dental insurance will not guarantee any payments until they receive & pay for my claim, even though they request for pre-authorization of pending treatments.

I understand that any deductibles, co-payments, underestimated patient portion, treatments or services that my insurance company does not want to pay for or does not want to cover, is my responsibility. If this office has underestimated my insurance portion or my portion, I will receive a bill to pay the difference.

I understand that I am to pay my co-portion at time of service and have agreed to pay the balance in full if my insurance does not pay after 30 days of my treatment.

I understand that this office, as a courtesy, is helping me finance my dental treatment for my remaining balance (my estimated dental insurance portion) for 30 days.

I understand I will continue to receive a bill which after 30 days will include 1.8% monthly finance charges & $15 monthly billing charges until my balance is paid in full.

I understand that I can speed up my Insurance payments by simply calling my Insurance Company to pay for my dental bill once they receive my claim.

I understand that if my insurance company does not pay my dental claim after this office had already billed them once, I may bill my own insurance, or have this office re-bill or resubmit my insurance claim for an additional charge of $10 per claim.

I understand that Emeryville Dental Care tries their best to estimate my portion based on what my insurance companies tell them over the phone and what they have historically paid to this office.

I understand Emeryville Dental Care cannot know every current detail of my insurance benefits and exclusions, but can supply me with estimated standard insurance information and will assist me to get my insurance company to help pay for my dental treatment and to help maximize my insurance benefits.

_____ **Photos/ Models/ X-Rays:**

I consent to release my intraoral and extraoral photographs/ pictures, diagnostic cast models, and x-rays for diagnostic purposes, insurance purposes, promotional/ advertising purposes, lab communication purposes, and educational purposes.

_____ **Other:**

I acknowledge that I have received from Emeryville Dental Care a copy of the Dental Materials Fact Sheet as required by law.

I understand I have a right to a copy of my x-rays with a minimum charge of $55 duplication fee or duplication of original x-rays for $220.

I understand that my original x-rays will not be released to me.

I understand that there is a returned check charge fee of $25 per incident. I understand that if I bounce a check and do not pay within 30 days, I will be charged 3 times the amount of the check (maximum $1500) plus the amount of the check per bounced check fee according to California Civil Code,Chapter 522,Section 1719

I understand that there is a minimum $35 charge per ½ hour appointed if I do not call the office more than 24 hours prior to my reserved appointment to cancel or reschedule. I will be charged $35 (5min to 30 minutes appt), $70 (31 minutes -1hr appt), $105 (1.1hr-2hrs appt), and so on. I understand that if I call the office to give them a courtesy 24 hours notice I will not be charged for canceling or rescheduling my reserved appointment for another day.

I understand that if I am more than 10 minutes late, this is considered a missed or canceled appointment with less than 24 hours notice & I will be charged the appropriate fees.

I understand that this consent form was written to prevent any misunderstands/ misconceptions between me, my dependents, and this dental office.

I understand that the Doctors avoid discussing finances with Patients because they are concentrating on my Quality dental care, treatment, & diagnosis.

I further agree that a photocopy of this agreement shall be valid as the original.

I understand that Emeryville Dental Care wants to ensure that I have a healthy, happy teeth, gums,& smile that will last the rest of my life!

I have read, understood, and agree to this entire agreement, and that any and all questions have been answered to my satisfaction, and agree to all terms stated herein.

I understand this agreement is governed by the City of Emeryville & County of Alameda, CA.

If any part of this agreement is deemed invalid, the remainder shall still be enforceable.

Patient's Name: Patient's (if Patient is a minor, Parent/ Guardian's) **Signature** : Today's Date : / /