TURNER DENTAL CARE .com

smile with us!

1 Patient Information

NAME _____ DATE OF BIRTH _____

HOME PHONE NUMBER (_____) _____ SS# _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ POSITION _____

BUSINESS PHONE NUMBER (_____) _____ PAGER (_____) _____

SPOUSE'S NAME _____ SPOUSE'S BUSINESS PHONE (_____) _____

WHO WILL PAY THIS ACCOUNT? _____ E-MAIL _____

WE CAN THANK _____ FOR YOUR REFERRAL.

2 Insurance Information

DENTAL INSURANCE CARRIER _____ INSURANCE PHONE (____)_____

INSURANCE BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURED /EMPLOYEE'S NAME_____ GROUP #_____EMPLOYEE'S DOB_____

EMPLOYED BY _____ EMPLOYEE'S SS#_____

DO YOU HAVE SECONDARY DENTAL INSURANCE? YES ☐ _____

3 Medical History

Have you ever had or do you have:

	YES	NO
ALLERGIES TO...		
PENICILLIN	☐	☐
LOCAL ANESTHETIC	☐	☐
OTHER DRUGS	☐	☐
PLEASE LIST _____		
HISTORY OF ABNORMAL BLEEDING	☐	☐
ANGINA OR PACEMAKER	☐	☐
HEART DISEASE OR M.V.P.	☐	☐
RHEUMATIC HEART DISEASE OR FEVER	☐	☐
HIGH BLOOD PRESSURE	☐	☐
SINUS PROBLEM	☐	☐
JOINT OR VALVE REPLACEMENT	☐	☐

	YES	NO
ARE YOU PREGNANT?	☐	☐
RESPIRATORY PROBLEMS	☐	☐
ASTHMA OR TUBERCULOSIS	☐	☐
HEPATITIS (A OR B)	☐	☐
DIABETES OR LEUKEMIA	☐	☐
HISTORY OF CANCER OR TUMOR	☐	☐
AIDS OR HIV	☐	☐
OTHER SERIOUS ILLNESS	☐	☐
_____	☐	☐
TAKING MEDICATION(S)?	☐	☐
LIST_____ _____		

ARE YOU PRESENTLY UNDER MEDICAL TREATMENT?_____

MY MEDICAL DOCTOR'S NAME:_____PHONE:_____

I consent to any and all examination and treatments which may be deemed advisable, including the administration of local anesthetics and other medications. **I understand that my financial responsibility is strictly between myself and the Doctor,** even though the office may assist me by billing my Dental Insurance Carrier. I understand that any insurance coverage quoted is only an estimate. **I understand that I must make full payment at the time professional services are rendered.** Any other arrangements must be made in writing before the services are begun.

4 Signature

_____ DATE

Patient Dental Information

Chart Number_____

Name_____ Date_____

Initial Concern_____

_____

Date of Last Dental Visit	Date of Last Dental Cleaning	Date of Last Full Set of X-

	YES
1. Do you have any Dental problems now?	☐
2. Do you have any teeth that are sensitive to	
Hot or cold?	☐
Sweets?	☐
Biting or chewing?	☐
3. Have you ever had:	
a. Orthodontic Treatment?	☐
b. Oral Surgery?	☐
c. Periodontal Treatment?	☐
e. A night guard or other appliance?	☐
4. Have you noticed any loosening or movement of your teeth?	☐
5. Does food tend to become caught between your teeth?	☐
6. Are you concerned with bad breath?	☐
7. Do you suffer from pain and/or swelling of your gums?	☐
8. Do your gums often bleed when you brush your teeth?	☐
9. Do you ever get sores in your mouth?	☐
10. Have you experienced:	
a. Clicking of the jaw?	☐
b. Pain (joint, ear, side of face)?	☐
c. Difficulty in opening or closing?	☐
d. Difficulty in chewing?	☐

	YES
11. Do You:	
a. Smoke or Chew tobacco?	☐
b. Clench or grind your teeth while awake or asleep?	☐
c. Bite your lips or cheeks regularly?	☐
d. Hold foreign objects with your teeth (such as pencils, pipe, pins or fingernails)?	☐
e. Mouth breathe while awake or asleep?	☐
f. Regularly suck on candy or mints?	☐
12. Do you have a history of gagging during dental treatment?	☐
13. Are you dissatisfied with the appearance of your teeth?	☐
14. Is there anything about your mouth or about having dental treatment that concerns you?	☐
15. Is there any history of allergy to latex?	☐

Explanation: _____

_____

_____

_____

Signature Date

FOR OFFICE USE ONLY

Home oral hygiene instruction given ..... ☐ Yes

Soft tissue within normal limits ..... ☐ Yes ☐ No (see chart)

Plaque Control ..... Good Fair Poor

Gingivitis ..... Generalized Localized

Periodontitis ..... Mild Moderate Severe ..... Generalized Localized

Occlusion ..... Class I Class II Class III

TMD ..... Popping Crepitus Pain Limited Opening

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes.

You must submit your request in writing to (insert practice/doctor name, or title, and telephone number of a person or office to contact for further information).

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to (insert practice/doctor name, or title, and telephone number of a person or office to contact for further information). You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact (insert practice/doctor name, title, and telephone number of the person or office responsible for handling complaints). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jeff Turner, D.D.S. ad (949)770-3294.

I hereby acknowledge that I have been presented with a copy of Jeff Turner, D.D.S. Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____

Office Policies

Jeff Turner, D.D.S.
23961 Calle de la Magdalena, Suite 205
Laguna Hills, CA 92653

Appointments: Please remember, appointment time is reserved exclusively for you. This enables us to better serve each patient. If it becomes necessary, please reschedule or cancel appointments with our office at least two business days in advance. Our office assesses a charge for the time lost due to a late cancellation or missed appointment. As a courtesy, a voice message concerning appointment information will be left at the phone numbers you provide.

Finances: Payment is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, and American Express. A $20 monthly late fee and an interest charge (18% annual percentage rate) will be assessed on all past due accounts. A bank fee will be charged on all returned checks.

Dental Insurance: As a courtesy to you, we will bill your insurance company for treatment rendered. However, it is the patient's responsibility to know the current status of their insurance coverage and benefits. Our staff will estimate your co-payment based upon the policy information provided by you. This amount will be due at the time of treatment. Actual coverage may vary from our estimate, as your insurance carrier ultimately determines participant eligibility and claim benefits. When our office receives an insurance payment, you will be billed for any amount not covered, which will be due in full upon receipt of the statement.

I understand and agree to the foregoing office policies and I hereby agree to accept responsibility for full payment of all treatment fees regardless of any insurance payment or participation.

In addition, I acknowledge that I have received a copy of the Dental Materials Fact Sheet and the Notice of Privacy Practices as required by California State law.

_____ _____

Signature of Patient or Responsible Party Date