Patient Information Form

Today's Date _____

Patient Name: First _____ MI ___ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

By Providing your e-mail address you agree to receive *(check one or both)* ☐ Appointment Reminders ☐ Practice Newsletter

What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ **Home Phone** _____ **Mobile Phone** _____

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Employer *(if different from above)* _____ **Occupation** _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____

Medical Plan Information

Plan Name _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ **Date of Birth** _____ **ID Number** _____

Policy Number _____ **Patient Relationship to Insured** _____ **Deductible Amount** _____

Whom may we thank for referring you?

☐ One of our valued patients *(name of patient)* _____

☐ Advertisement _____ ☐ Local Dental Society _____

☐ Our Web site ☐ Other _____

Please list other members of your immediate family who are patients in our practice

_____ _____ _____ _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

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 _____
** Please 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 or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

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.

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

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

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

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. YES / NO (Circle One) _____ (initial)

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. _____ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Signature _____ Date _____

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI ____ Last _____ **Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain _____
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain _____
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam? _____ **Reason for exam** _____
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain _____
   Date of last dental exam _____ **Name of last treating dentist** _____
6. **Yes / No** **Are you in pain now?**
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking _____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** _____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why _____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Patient Communication Policy

It is important to note that standard email and text communication is not always secure. Email and text messages can be intercepted and for this reason, our practice does not communicate personal health information through this method. Our Practice will never ask for account information, credit card numbers, or personal information via email or text message. If you think you may have received a suspicious email or text from our practice, please contact our office immediately at:

Dr. Neel Syal
1400 Townview Lane
Santa Rosa, CA 95405
T: (707) 578-8100

Email Appointment Confirmations

By enrolling in email appointment confirmations, you may receive non-appointment related emails throughout the course of your subscription with our office. Emails may include special offers for your specific location or alerts notifying you about important office news and events.

At this time, if you subscribe to receive email appointment confirmations, you automatically are subscribed to receive any marketing-related email. We promise that we will not spam your account with unnecessary emails, nor will we sell your information to a third party.

Text Appointment Confirmations

By enrolling in text appointment confirmations, you are authorizing our office to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that your represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

Email To Other Doctors

Upon written request from you, we may release x-rays and treatment information to other practices and/or specialists on your behalf. Please note that all email communications from this office are sent using a secure, encrypted email program and the receiving practice will be prompted to create a username and password to securely access your records. Some offices may wish to not utilize this secure portal, in
which case, a printed copy of your records can be mailed to their practice.

Dr. Neel Syal
1400 Townview Lane
Santa Rosa, CA 95405
T: (707) 578-8100

Patient Consent for Electronic Communication

Our office utilizes the convenience of email. By using our practice's electronic services, you agree that our office may send to you any of the following that you identify as a communication that can be sent through the internet to an email address you designate. All electronic communications from our practice to you will be sent from our secured, non-encrypted email server.

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 email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is: _____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My email address is: _____

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

_____

Name Date

Consent for Leaving Messages

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for us to do so.

I give permission for messages to be left on my phone number(s) below:

☐ Cell # _____ ☐ Work # _____

☐ Home # _____ ☐ I prefer to not have voicemail messages

Regarding the following:

☐ Appointment Reminders/Changes ☐ Cost Estimates

☐ Account Payments/Balances ☐ Needed Treatment/Completed

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Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for **Dr. Neel Syal** and representatives at our practice to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my care or relevant for payment.
Regarding the following:

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Regarding the following:

☐ Appointment Reminders/Changes
☐ Cost Estimates
☐ Account Payments/Balances
☐ Needed Treatment/Completed

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

Neel Syal, D.D.S. 1400 Townview Lane, Santa Rosa, CA, 95405 (707) 578-8100

Acknowledgement of Receipt of Notice of Privacy Practices and the California Dental Materials Fact Sheet

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. The Dental Board of California has prepared The Dental Material Facts Sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices and the California Dental Board's "Facts About Fillings" Dental Materials Fact Sheet. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received the Privacy Notice and the California Dental Materials Fact Sheet. This document is not a contract, authorization or consent form.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

Patient Name: _____
We attempted to obtain written acknowledgement of receipt of our office Notice of Privacy Practices and Dental Materials Fact Sheet, however, acknowledgement could not be obtained due to:

- ☐ Patient refused to sign
- ☐ Patient communication barrier
- ☐ Emergency Situation

Completed by:

_____
Employee Signature Title Date