WELCOME

South Coast Dental Specialties

949-363-2540

1. ABOUT YOU

Today's Date:_____/_____/_____

Patient Name: _____

Last First MI

What You Prefer To Be Called:_____

❑ Male ❑ Female

Birth Date:_____/_____/____ Age: _____

SS #: _____–_____

Mailing Address: _____

CITY_____ STATE_____ ZIP_____

Home Phone #: _____

Work Phone #:_____ Ext: _____

Cell Phone #:_____

E-mail Address:_____

Referred By:_____

Employer:_____How Long?_____

Employer's Address:_____

_____

City State Zip

Occupation:_____

Status:

❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Seperated ❑ Widowed

Spouse's Name:_____

Do you have children? ❑ Yes ❑ No How many?_____

2. INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address: _____

_____

CITY_____STATE_____ ZIP_____

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Date of Birth:_____/_____/_____

Insured's Employer:_____

Secondary Dental Insurance

Co. Name:_____

Address: _____

_____

CITY_____STATE_____ ZIP_____

Phone #:_____

Insured's SS#:_____

Group # (Plan, Local or Policy #):_____—___

Insured's Name:_____

Relation:_____Date of Birth:_____/_____/_____

Insured's Employer:_____

3. ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY_____ STATE_____ ZIP_____

SS #: _____

Driver's License #:_____

Work Phone #:_____

Payment Method: ❑ Cash ❑ Check

_____ / _____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4. IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

5. MEDICAL HISTORY

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: Have you taken any medication or drugs during the past two years? ..... Yes No
Are you taking any medication, drugs or pills now? ..... Yes No
If yes, please list name and dosage _____
Are you taking any Blood Thinners (Aspirin, Warfarin (Cumadin) Plavix, Xarelto)? ..... Yes No
If yes, please list name and dosage _____
Have you ever taken or are currently taking Biophoshonates (Actonel, Boniva, Fosomax) or Prolia or Denosuab ..... Yes No
If yes, please list name and dosage _____
Have you ever taken prescription medications for weight losss (diet pills?) ..... Yes No
If yes, which one and for how long _____
If yes, to any on the above, did you have a medical exam for heart issues? ..... Yes No
Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? ..... Yes No
If yes, please list: _____
Have you been a patient in the hospital during the past five years? ..... Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Diabetes	Yes	No	Hepatitis C	Yes	No
Chest Pain	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Glaucoma	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Contact lenses	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Latex Sensitivity	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Sinus Trouble	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Radiation Therapy	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Nervous/Anxious	Yes	No
Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
If yes, please list: _____

Women. Are you: **Pregnant**? Yes, ____Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that this practice provides space, equipment, support personnel, and administrative services to facilitate each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgment in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THE DENTAL MANAGEMENT COMPANY.

_____ _____

Signature of patient (parent or guardian) Date Signature of dentist _____ Date

X11. 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's initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

South Coast Dental Specialties

30190 Town Center Drive, Suite B
Laguna Niguel, CA 92677
(949) 363.2540
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www.scdentalspecialties.com

INSURANCE AND FINANCIAL POLICY

At SOUTH COAST DENTAL SPECIALTIES, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We currently accept *all* private care insurance plans and most managed care plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment given by a company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We "estimate" your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "Pre-treatment Authorization" with your insurance company prior to treatment. This does delay treatment, but will give you the exact out-of-pocket expense figures you may require.

We bill your insurance as a "courtesy". If your insurance does not pay within 90 days, SOUTH COAST DENTAL SPECIALTIES reserves the right to request payment in full for services from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

SOUTH COAST DENTAL SPECIALTIES *does require payment in full for your portion* at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with "Care Credit", which offers a 12-month "same as cash" or longer terms with an interest-bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of our Patient Services staff for an application.

Broken Appointments: A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 24-hour notice to avoid a $35/hour cancellation fee (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print Name: _____

Signature: _____ Date: _____

South Coast Dental Specialties

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Laguna Niguel, CA 92677
(949) 363.2540
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www.scdentalspecialties.com

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed/received a copy of this Dental Practice's **HIPPA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):
o Parent o Guardian o Power of Attorney o Other:_____

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

FOR OFFICE USE *ONLY* BELOW

PLEASE SPECIFY THE REASON THE PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGMENT OF RECIEPT OF THE HIPPA NOTICE OF PRIVACY PRACTICE

_____

_____

Signature: _____ Date: _____

Title: _____