WELCOME

to ERRINGER FAMILY DENTAL GROUP
1755 Erringer Road, Suite 21 * Simi Valley, CA, 93065
(805) 522-7370 Fax: (805) 522-2780

ABOUT YOU

Today's Date: _____

Name: _____

I Like To Be Called: _____

Home Address: _____

_____

_____

Mailing Address (IF DIFFERENT FROM ABOVE):

_____

_____

Social Security #: _____

Your Employer: _____

Occupation: _____

Birthday: _____ ☐ Male ☐ Female

Single Married Divorced Widowed

Special Interests, Sports, Or Hobbies: _____

_____

Referred By: _____

DENTAL INSURANCE

Do you have dental insurance through your employer?
Y / N (If YES, please provide the following info)

Dental Insurance Co. #1: _____

Subscriber ID: _____

Group #: _____

Insurance Co. Phone #: _____

Your Employers Name: _____

DO YOU HAVE OTHER DENTAL INSURANCE COVERAGE?
☐ YES ☐ NO

This coverage is through your (please circle one):

Spouse Parent Other:

Their Name: _____

Their Employers Name: _____

Their Social Security #: _____

Their Birthdate: _____

Dental Insurance Co. #2: _____

Group #: _____

Insurance Co. Phone#: _____

TELEPHONE

Home #: _____

Cell #: _____

Work #: _____ Ext#: _____

What is the best time if day to reach you? _____

Where? _____ Specific Days? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Address: _____

Relationship: _____ Work#: _____ Home Or Cell: _____

DENTAL HISTORY

Previous Dentist's Information

Their name:_____ Their phone:_____

Their address:_____

_____

1. Date of: Last dental visit:_____ Last cleaning:_____ Full mouth x-rays:_____
2. What was done at your last visit:_____
3. How often do you have dental examinations?_____
4. How often do you brush your teeth?_____ Floss?_____
5. Y / N Have you ever used or are you currently using fluoride?
6. What other dental aides do you use (toothpick, water pick, etc.)?_____
7. Y/ N Do you have any other dental problems?
8. Y / N do you feel nervous about having dental treatment?
9. Y / N have you ever had an upsetting dental experience?
10. Y / N have you ever been told to take a pre-medication prior to dental treatment?
11. Y /N is there anything else about having dental treatment that you would like us to know?
12. If you answered YES to any of the questions above, please describe below:

_____

_____

_____

13. Please circle Y or N for the following questions

DO YOU:

Y / N Clench or grind your teeth while awake or asleep?
Y / N Bite your lips or cheeks regularly
Y / N Hold foreign objects with your teeth? (pencils, pipe, etc.)
Y / N Mouth breathe while asleep or awake
Y / N Have tired jaws, especially in the morning?
Y /N Snore or have any other sleeping disorders?
Y / N Smoke/vape/chew tobacco products?

HAVE YOU EXPERIENCED:

Y / N Clicking or popping of the jaw
Y / N Pain (joint, ear, side of face)
Y / N Difficulty in opening or closing the mouth
Y / N Difficulty in chewing on either side of the mouth
Y / N Headaches, neck aches, or shoulder aches
Y / N Sore muscles (neck, shoulders)
Y / N Are you satisfied with your teeth's appearance?
Y / N Would you like to replace your silver fillings?
Y / N Would you like to keep all of your teeth all of your life?

HAVE YOU EVER HAD:

Y / N Orthodontic treatment
Y / N Oral surgery
Y / N Periodontal treatment
Y / N Your teeth ground or the bite adjusted
Y / N A bite plate or mouth guard
Y / N A serious injury to the mouth or head

ARE ANY OF YOUR TEETH SENSITIVE TO:

Y / N Hot, cold, or sweets
Y / N Biting or chewing
Y / N Do you frequently get cold sores, blisters, or other lesions?
Y / N Do your gums bleed or hurt?
Y / N Have your parents experienced gum disease or tooth loss?
Y / N Have you noticed any loose teeth or change in your bite?
Y / N Does food tend to become caught in between your teeth?

MEDICAL HISTORY

1. Physician's name: _____ Phone: _____

2. Have you had any medical care within the past 2 years? Y/N
3. Have you taken any medication or drugs during the past 2 years? Y/N
4. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin? Y/N
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, bovina, or other bisphosphonates? Y/N
6. Are you aware of having an allergic or adverse reaction to any of the following drugs?

Y / N Penicillin	Y / N Erythromycin	Y / N Latex
Y/ N Dental Anesthetics	Y / N Tetracycline	Y / N Codeine
Y / N Sulfa	Y / N Aspirin	

7. Are you allergic or sensitive to any other drugs? Y/ N
8. Have you been a patient in the hospital during the past 5 years? Y/N
9. Have you lost or gained more than 10 pounds in the past year? Y/N
10. Women: are you pregnant or think you could be pregnant? Y/N
11. Do you use birth control prescriptions? Y/N
12. If you answered YES to any of the questions, please describe below:

_____

_____

_____

13. Indicate which of the following you have had, or have at present:

Y/N heart (surgery, disease, attack)	Y/N ulcers	Y/N bruise easily	Y/N blood transfusion
Y/N chest pain	Y/N diabetes	Y/N liver disease/yellow jaundice	Y/N hemophilia
Y/N congenital heart disease	Y/N thyroid problems	Y/N neurological disorders	Y/N sickle cell disease
Y/N heart murmur	Y/N glaucoma	Y/N epilepsy or seizures	Y/N diuretic
Y/N high/low blood pressure	Y/N contact lenses	Y/N fainting or dizzy spells	Y/N sinus trouble
Y/N mitral valve prolapse	Y/N emphysema	Y/N nervous/anxious	Y/N radiation therapy
Y/N artificial pacemaker	Y/N chronic cough	Y/N psychiatric/psychological care	Y/N chemotherapy
Y/N rheumatism/arthritis	Y/N tuberculosis	Y/N cancer	Y/N tumors
Y/N cortisone medicine	Y/N asthma	Y/N hepatitis a, b, c	Y/N artificial joints (hip, knee, etc.)
Y/N swollen ankles	Y/N hay fever/allergy/hives	Y/N venereal disease	Y/N kidney trouble
Y/N diet(special/restricted)	Y/N latex sensitivity	Y/N AIDS/HIV	Y/N stroke
	Y/N COVID-19	Y/N cold sores/fever blisters	Y/N rheumatic fever

14. Do you have, or have you had any disease, condition, or problem not listed? Y/N
    If YES, please list: _____

*OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA

***PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED**

*I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE EFFICIENT MANNER. I HAVE ANSWERED ALL THE QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK MY HEALTHCARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

Patient name: _____ Date: _____

Relationship to patient: _____ Signature: _____

PATIENT CONFIDENTIALITY

PATIENT CONFIDENTIALITY IS APRIME CONCERN IN THIS OFFICE. PLEASE INDICATE BELOW WITH WHOM OUR OFFICE CAN OR CANNOT LEAVE A MESSAGE.

PLEASE CHECK ONE WHERE APPROPRIATE

	YES	NO	DOESN'T APPLY
SPOUSE	☐	☐	☐
CHILDREN	☐	☐	☐
ANSWERING MACHINE	☐	☐	☐
EMAIL	☐	☐	☐

(YOUR ADDRESS IF YES) _____

FAX	☐	☐	☐

(YOUR FAX # IF YES) _____

Y / N ARE YOU ABLE TO RECEIVE CALLS AT YOUR WORKPLACE?

Y / N MAY WE CALL YOU AT YOUR WORKPLACE AND STATE WHO IS CALLING?

DUE TO HIPAA CONFIDENTIALIT REGULATIONS, SHOULD A FAAMILY MEMBER, FRIEND, OR RELATIVE CONTACT OUR OFFICE, WE ARE NOT AT LIBERTY TO DISCUSS YOUR SITUATION UNLESS WE HAVE PERMISSION FROM YOU-THE PATIENT.

PLEASE CHECK WITH WHOM WE MAY DISCUSS YOUR SITUATION

	YES	NO	DOESN'T APPLY
SPOUSE	☐	☐	☐
CHILDREN	☐	☐	☐

CHILDREN AND/OR SIGNIFICANT OTHER:

NAME _____

RELATIONSHIP _____

PHONE _____

NAME _____

RELATIONSHIP _____

PHONE _____

PLEASE SIGN: _____ DATE: _____

FINANCIAL AND INSURANCE POLICIES

Feel free to ask any questions about that may have regarding our policies or costs.

An appointment to visit our office reserves the time exclusively for you. Failing to keep a reserved appointment will result in a charge of *$25 PER HALF HOUR. NO FEES* will be charged for rescheduling an appointment provided a *48 HOUR OR MORE* notice is given.

We respect your desire to make a responsible decision regarding your treatment and its related fees. The benefits, alternative treatments, possible risks, and financial aspects of your procedure will be discussed so that you may make a well-informed decision to refuse or accept the recommended treatment.

**ACCEPTANCE FOR TREATMENT IMPLIES THAT YOU UNDERSTAND AND CONSENT TO ALL TREATMENT PROCEDURES AND FEES INVOLVED.*

If insured: it is not easy for an office to become familiar with the details of every dental plan it encounters. It is the responsibility of the patient, not the dental office employees, to know what is covered and what is excluded from their particular dental plan.

Although we strive to give our patients the best quality care, our office does appreciate your assistance with any matters that pertain to your insurance coverage. As a courtesy we will submit your dental insurance claim and accept assignment of benefits, if the information we need from you is provided in a timely manner. Your treatment will not be compromised in order to meet the usual and customary fees that your insurance company may impose.

Insurance figures are estimates only!! It is important for you to understand that insurance benefits generally do not cover the entire fee. The difference owed must be paid by you. Dental insurance does not absolve you of the financial responsibility for treatment rendered. Certain dental plans require the predetermination for specific procedures or when charges are expected to exceed a certain amount. All dental offices and insurance companies are required to follow a set of procedure codes setup by the American Dental Association to describe a specific dental procedure. The existence of a dental procedure code cannot guarantee coverage by the insurance carrier.

Regardless of insurance: the patient portion owed is expected to be paid in cash, check, or major credit card on the day of treatment. Mastercard, visa, American Express, and discover are accepted by our office for your convenience. We offer an interest free payment plan through care credit subject to credit approval. *THERE IS A $25 HANDLING AND BOOKING FEE FOR ANY RETURNED CHECKS.*

*When your balance remains unpaid after 60 days, your account becomes delinquent. A late charge will accrue on the account balance at the rate of 1.5% per month (18% annually). You will also receive a letter stating that in 30 days your account will be sent to collections. Any fees, including court and attorney fees will be the responsibility of the guarantor.

FAILURE TO SIGN THIS AGREEMENT DOES NOT NEGATE OR ABSOLVE YOUR FINANCIAL OBLIGATION FOR ANY OF YOUR PREVIOUS OR FUTURE TREATMENT AT THIS OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS THAT ARE NOT PAID BY MY DENTAL PLAN. I UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE OFFICE POLICIES.

Patient name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

ERRINGER FAMILY DENTAL GROUP
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Privacy Pledge and Duties.

While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice, we will notify you during your next visit or by mail.

II. Permissible Uses and Disclosures Without Authorization.

In certain situations (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations.

1. Treatment. Your hearing health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition.

2. Payment. Our insurance and billing staff may disclose your health information to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care.

3. Health Care Operations. Your hearing health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.

4. Appointment Reminders. Your hearing health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request.

5. Other Providers. Your hearing health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosures to Relatives, Close Friends and Other Caregivers. Your hearing health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your hearing health care professional.

If you are not present, you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition.

C. Other Permitted Uses and Disclosures Without Your Authorization. Under federal law, we are also permitted or required to use or disclose your health information without your authorization in these following circumstances:

1. Public Health Activities. We may disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

2. Victim of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

3. Health Oversight Activities. We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health care programs such as Medicare or Medicaid.

4. Judicial and Administrative Proceedings. We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

5. Law Enforcement Officials. We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

6. Decedents. We may disclose your health information to a coroner or medical examiner as authorized by law.

7. Organ and Tissue Procurement. We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

8. Research. We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure.

9. Health or Safety. We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

10. Specialized Government Functions. We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

11. Workers' Compensation. We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

12. As Required by Law. We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III. Uses and Disclosures Requiring Your Authorization.

A. Uses or Disclosure with Your Authorization. Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

B. Your Right to Revoke Your Authorization. You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have taken an action in reliance upon such authorization before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at the address given in Section VII below.

C. Marketing. We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.

D. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization.

E. Right to Refuse Authorization. You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact you for purposes other than those set forth in Section II above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

IV. Your Individual Rights.

A. Your Right to Receive Confidential Communication Regarding Your Health Information. We normally provide information about your health in person, at the time you receive hearing care services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any requests in writing.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding

your general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

C. Your Right to Inspect and Copy Your Health Information. You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect an/or copy your health information to be in writing. If you request copies, we will charge you **$20.00**. We will also charge you for our postage costs, if you request that we mail the copies to you.

D. Your Right to Amend Your Health Information. You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

E. Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records. You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures that occurred prior to April 14, 2003. The accounting will include all disclosures except those disclosures:

- required to carry out treatment, payment and health care operations to you.
  - that are incident to a permitted use or disclosure.
  - made pursuant to an authorization.
  - required to maintain a directory of the individuals in our facility or to individuals involved with your care.
  - required for national security or intelligence purposes.
  - to correctional institutions or law enforcement officers.
  - made as part of a limited data set.
  - made prior to April 14, 2003.

If you request an accounting more than once during a twelve (12) month period, we will charge **$0.25** per page of the accounting statement.

V. Re-Disclosure.

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal law.

VII. Your Right to Obtain Further Information; Complaints.

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint or request information at any time, written comments should be addressed to:

ERRINGER FAMILY DENTAL GROUP
1755 ERRINGER ROAD, SUITE 21
SIMI VALLEY, CA, 93065

VIII. Your Right to Receive a Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

IX. Effective Date. This Notice is effective as of April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____
HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY

WE ATTEMPT TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECAUSE:

- ☐ INDIVIDUAL REFUSED TO SIGN
- ☐ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- ☐ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
- ☐ OTHER (PLEASE SPECIFY): _____

_____

_____