Yuba City Dentistry Group
Medical History

Patient Name:

Medical History as on :

Patient Medical Information

Allergies

- ☐ Y ☐ N Other (see PN)
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Cipro
- ☐ Y ☐ N Clindamycin
- ☐ Y ☐ N Codeine/Other narcotics
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Ibuprofen
- ☐ Y ☐ N Keflex
- ☐ Y ☐ N Tylenol
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Vicodin

Check, if applicable

- ☐ Y ☐ N AIDS
- ☐ Y ☐ N HIV
- ☐ Y ☐ N Anemia/Leukemia
- ☐ Y ☐ N Asthma/Hay Fever
- ☐ Y ☐ N Bisphosphonates
- ☐ Y ☐ N Blood clotting problems
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain upon Exertion
- ☐ Y ☐ N Coumadin/Blood Thinners
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting Spells/Seizures
- ☐ Y ☐ N Fever Blisters / Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently dry mouth
- ☐ Y ☐ N Heart-Atrial Fibrillation
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart disease/Angina
- ☐ Y ☐ N Heart Valve Infection (bacteri
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Hepatitis/Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney Problems
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental health challenges
- ☐ Y ☐ N Osteoporosis
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N See Medication list

Dental Questionnaire

Dental Questionnaire - Please check "YES" answers only

Do you Chew/Smoke Tobacco in any form ?	☐
Does food catch between your teeth ?	☐
How often do you floss your teeth?	
Do your Gums ever Bleed while Brushing or Flossing ?	☐
Do you have any unpleasant taste or odor in your mouth?	☐
Are any teeth Sensitive to Hot, Cold or Sweets ?	☐
Have you had any Head, Neck or Jaw injuries?	☐
If Yes, please explain	
Do you Notice Popping, Clicking or Soreness of the Jaws or in front of the Ears ?	☐
Do you have difficulty opening your mouth wide or holding it open for long periods of time?	☐
Do you Clench or Grind your teeth ?	☐
Do you have DISCOLORED teeth that bother you?	
Have you experienced a change or shifting in bite?	
Do you have a family history of periodontal disease?	

In order to better serve you

Have you had an unfavorable reaction to local anesthetic?	
Does dental treatment make you nervous?	
Would you desire to be pre-sedated?	
On a scale of 1-10 what would you like your smile to be?	
On a scale 1-10 how would you rate your smile (10 being the greatest 1 being the lowest)?	

ave you ever had a negative dental experience that you can tell us?	
o you have a specific dental concern today?	☐
yes, please briefly explain	

Medical Questionnaire

re you currently under the care of a Physician?	☐
Yes, What is the condition being treated?	
lave you been Hospitalized within the past 5 years?	☐
Yes, what illness or Problem was treated?	
lave you had any major surgeries in the last 10 years?	☐
Yes, Please Explain	
re you currently taking any Prescription Medications?	☐
If Yes, What Medications?	
Are you or have you ever taken any Bisphosphonates medications?	☐
s there any Disease, Condition, or Problem not Listed ?	☐
f Yes, Please explain	

Women Only

Are you Pregnant?	☐
Are you Nursing ?	☐
Are you taking Birth Control Pills?	☐
Are you taking fertility medications?	☐

By signing below, I certify that all of the above information is true to the best of my knowledge.

DO NOT SIGN

Patient Signature

ture

Date

Date

1 GENERAL DENTISTRY CONSENT and OFFICE POLICY

GENERAL DENTISTRY CONSENT

1. EXAMINATION AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

2. DRUGS, MEDICATION AND SEDATION

I have informed the Dentist of any known allergies. I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication, and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to stop during any procedure and make me aware of any/all changes, clinical and financial, that may effect the current treatment originally discussed and signed for. I will then be able to make a decision whether or not to continue with treatment.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

5. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

FINANCIAL POLICY

We want you to obtain the best dentistry for yourself. If you have dental insurance we will bill your dental insurance for you. We will do our best at estimating your insurance's co-pay and estimating your co-pay. However, please know these are estimates and dental insurances do not always guarantee payments that have been estimated and may provide only the minimum standard of care. The policy holder is responsible for any treatment not covered by their dental insurance. If your insurance company has not paid your account in full within 60 days, the patient's responsibility is to pay the remaining balance. Copayments are due at the time of service. We have several options available to pay for services; cash, check, credit card, and in office financing via Care Credit.

INSUFFICIENT FUNDS/RETURNED CHECKS

For any check returned due to insufficient funds results in a $25 charge assessed to your account and $35 charge for each additional check. There will be a $10 late fee per month for any payment that is over due plus 1.5% interest may be added monthly to your overdue balance.

CANCELLATIONS AND FAILED APPOINTMENTS

Keeping your appointment is important to us. Failure to keep your scheduled appointment means we could have helped another patient during that time. If you need to reschedule an appointment we ask you do so 48 hours in advance, there may be a $50 late cancellation or no show fee. As a courtesy we try to remind you of your appointments.

By signing below, I acknowledge my Dr's. Office Policy.
By signing below, I acknowledge the General Dentistry Informed Consent
Patient's/Parent's/Guardian's Signature X

Date:

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. Access: You have the right to look at or get copies of your health information, with limited exceptions. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $0.20 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.

By signing below I consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

X _____

DATE. _____

FINANCIAL POLICY:

We want you to obtain the best dentistry for yourself. If you have dental insurance as a courtesy we will bill your dental insurance for you. We will do our best at estimating your insurance's co-pay and estimating your co-pay. However, please know that these are estimates and dental insurances do not always guarantee payments that have been estimated. You are responsible for any treatment not covered by your dental insurance. If your insurance has not paid your account in full within 60 days, your responsibility is to pay the remaining balance.

PAYMENT OPTIONS:

Copayments are due at the time of service. We have several options available to pay for services; Some services are eligible for a 5% discount if paid by Cash or Check (if paying for your entire treatment in full)

We Accept Credit Cards: American Express, Mastercard, Visa, & Discover.

We also accept Care Credit so you may finance your dental work at 0% interest (ask us how)

INSUFFICIENT FUNDS/RETURNED CHECKS:

For any check returned due to insufficient funds a $30 charge will be assessed to your account. If your account becomes delinquent and is referred to a Collection Agency, there will be a 30% collection fee added to your account before assignment.

By signing below, I acknowledge Placerville Dental Group's Office Financial Policy.

X _____

DATE _____

11/19/1998

I agree that Yuba City Dentistry Group may communicate with me electronically at the email address and cell phone numbers I have provided.

I understand that Yuba City Dentistry group may send updates, promotions, appointment confirmations, and insurance verification. By signing below I understand that there is some level of risk that third parties might be able to read unencrypted emails.

_____

X _____

DATE _____

COVID-19

I, _____, understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus by merely being in a dental office.

I have been made aware of the CDC, CDA, and ADA guidelines that under the current pandemic, all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit regular operation of teeth and mouth, and issues that may cause anything listed above within the next 6-12 months.

I confirm I am seeking treatment for a condition that meets these criteria.

I confirm that I am not presenting any of the following symptoms of COVOID-19 listed below:
- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for period of 14 days to anyone who has, and this is not possible with dentistry.

I verify I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19.

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days.

X _____

DATE. _____