WELCOME TO PARK SARATOGA DENTAL!

Kathleen Ban, DDS
12132 Saratoga-Sunnyvale Rd.
Saratoga, CA 95070
(408)252-5678

NEW PATIENT INFORMATION (Confidential)

PATIENT NAME: _____ Date: _____
LAST FIRST (Preferred Name)

ADDRESS: _____
STREET APT. # CITY ST. ZIP CODE

Social Security #: _____-_____-_____ Birth Date: _____/_____/_____
(INSURANCE PURPOSES)

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail:_____
(REMINDERS, CONFIRMATION AND SEND RECORDS. NO SPAM.)

**In Case of Emergency, Call*: _____ Name: _____ Relationship: _____

Whom may we thank for referring you? [ ] Existing Patient [ ] Dental Office [ ] Relative [ ] Friend [ ] Internet [ ] Work
Name of Person or Office: _____

[ ] Yes, I give consent to Park Saratoga Dental using my cell phone number to call and/or text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

[ ] Yes, I give my consent to receiving e-mails from Park Saratoga Dental regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.
[ ] No, I do NOT wish to receive e-mails from Park Saratoga Dental regarding treatment, insurance, and my account.

I hereby give permission to Park Saratoga Dental, Kathleen Ban DDS, and Staff to disclose and discuss any information related to my medical/dental conditions(s) to/with the following family members(s), other relatives(s), and/or close personal friends(s):

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____
[ ] I do NOT wish to give permission for any family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

Date of Last Dental Visit: _____ Reason For Todays' Visit: _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING (Circle)**:**

Aspirin – Local Anesthetic – Erythromycin – **Latex** – Nitrous Oxide – Codeine – **Penicillin** – **Sulfa** – Other: _____

Have you ever taken any of the following? (Circle)**:**

Bisphosphonates, Boniva, Calcitonin, Denosumab, Evista, Fosamax, Forteo, Strontium Ranelate □ Yes □ No

If Yes, please explain: _____

Have you have/had any of the following? Please check Yes (Y) or No (N)

Y/N	Y/N	Y/N	Y/N
□□ AIDS/HIV	□□ Excessive Bleeding	□□ Liver Disease	□□ Stroke
□□ Dizziness	□□ Fainting	□□ Mental Disorders	□□ Tuberculosis
□□ Glaucoma	□□ Epilepsy	□□ Nervous Disorders	□□ Jaundice
□□ Anemia	□□ Growths/Tumors	□□ Pacemaker	□□ Ulcers
□□ Arthritis	□□ Hay Fever	□□ Venereal Disease	□□ Depression
□□ Artificial Joints/Hips	□□ Head Injuries	□□ Sinus Problems	
□□ Asthma	□□ Heart Disease	□□ Radiation Treatment	□□ Kidney Disease
□□ Blood Disease	□□ Heart Murmur	□□ Respirator Problems	□□ Tobacco Habit
□□ Cancer	□□ Hepatitis	□□ Rheumatic Fever	□□ Thyroid Problems
□□ Diabetes	□□ High Blood Pressure	□□ Stomach Problems	

Other: _____

Woman only:

1. Are you pregnant? □ Yes □ No 2. Are you nursing □ Yes □ No 3. Are you taking oral contraceptives? □ Yes □ No

Have you ever had any complications following any dental treatment? □ Yes □ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No
If yes, please explain: _____

Please list **all medications** you are currently taking:

_____

Do you take **antibiotics** (Pre-Med) before dental treatment? □ Yes □ No If Yes, for what medical condition?

_____

Are there **any medical conditions** that the Doctor should be aware of? □ Yes □ No If Yes, Please Explain:

_____

Are you currently under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____Phone: _____

Do you have any health problems that need further clarification? □ Yes □ No
If yes, please explain: _____

Employment Information: [ ] Employed [ ] Self-Employed [ ] Un-Employed [ ] Student [ ] Other

Employer Name: _____ Occupation: _____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment.

_____ _____
SIGNATURE of Patient, Parent or Guardian Date:

_____ _____
PRINT NAME of Patient, Parent or Guardian Date:

HIPAA PATIENT CONSENT FORM

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- •Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- •Obtaining payment from third party payers (e.g. my insurance company)
- •The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____

SIGNATURE of Patient, Parent or Guardian

_____ Date: _____

PRINT NAME of Patient, Parent or Guardian