BioDental Healing

Date _____

Patient Information

Name _____ DOB _____
First MI Last

Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Patient Medical History

Are you under a physician's care now? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you take Premedicate for your dental visits? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No _____

Have you ever taken any Bisphosphonates (XGVEA)? ☐ Yes ☐ No _____

List all current medications currently taking: _____

_____

Women: ☐ Are you Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Are you allergic to any of the following: _____

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic Metal	☐ Latex
☐ Local Anesthetics	☐ Sulfa Drugs	☐ Nitrous Oxide	☐ Valium	☐ Demerol
☐ Erythromycin	☐ Tetracycline	☐ Vicodin	☐ Percodan	☐ Other: _____

Have you experienced any of the following in the last 6 months: _____

☐ Chest Pain	☐ Cough	☐ Constipation	☐ Frequent Urinating	☐ Thirst
☐ Fever	☐ Bleeding	☐ Headache	☐ Blurred Vision	☐ Dry Mouth
☐ Night Sweats	☐ Diarrhea	☐ Vomiting	☐ Dizziness	☐ Swollen

Are you taking or have taken any of the following: _____

☐ Recreational Drugs	☐ Acetaminophen	☐ Antibiotics	☐ Antihistamines	☐ Aspirin
☐ Blood Thinners	☐ Blood Pressure Med.	☐ Cold Remedies	☐ Digitalis/Heart Medication	☐ Nitroglycerin
☐ Steriods/ Cortisone	☐ Thyroid Medicine	☐ Tranquilizers	☐ Insulin/Diabetes Drugs	☐ Vitamins

Patient Medical History

Do you have or have had, any of the following:

Y / N		Y / N		Y / N		Y / N	
☐ ☐	AIDS/HIV Positive	☐ ☐	Convulsions	☐ ☐	Hemophilia	☐ ☐	Recent Weight Loss
☐ ☐	Alzheimer's Disease	☐ ☐	Cortisone Medicine	☐ ☐	Hepatitis A	☐ ☐	Renal Dialysis
☐ ☐	Anaphylaxis	☐ ☐	Diabetes	☐ ☐	Hepatitis B or C	☐ ☐	Rheumatic Fever
☐ ☐	Anemia	☐ ☐	Drug Addiction	☐ ☐	Herpes	☐ ☐	Rheumatism
☐ ☐	Angina	☐ ☐	Easily Winded	☐ ☐	High Blood Pressure	☐ ☐	Sickle Cell Disease
☐ ☐	Arthritis/Gout	☐ ☐	Emphysema	☐ ☐	Hives or Rash	☐ ☐	Sinus Trouble
☐ ☐	Artificial Heart Valve	☐ ☐	Epilepsy of Seizures	☐ ☐	Hypoglycemia	☐ ☐	Intestinal Disease
☐ ☐	Asthma	☐ ☐	Excessive Bleeding	☐ ☐	Irregular Heartbeat	☐ ☐	Swelling of Limbs
☐ ☐	Blood Disease	☐ ☐	Fainting Spells/Dizziness	☐ ☐	Leukemia	☐ ☐	Thyroid Disease
☐ ☐	Blood Transfusion	☐ ☐	Frequent Cough	☐ ☐	Liver Disease	☐ ☐	Tonsillitis
☐ ☐	Bruise Easily	☐ ☐	Frequent Diarrhea	☐ ☐	Low Blood Pressure	☐ ☐	Tuberculosis
☐ ☐	Cancer	☐ ☐	Genital Herpes	☐ ☐	Lyme Desease	☐ ☐	Tumors or Growths
☐ ☐	Chemotherapy	☐ ☐	Hay Fever	☐ ☐	Mitral Valve Prolapse	☐ ☐	Ulcers
☐ ☐	Chest Pain	☐ ☐	Heart Attack/Failure	☐ ☐	Parathyroid Disease	☐ ☐	Venereal Disease
☐ ☐	Cold Sores/Fever Blisters	☐ ☐	Heart Murmur	☐ ☐	Psychiatric Care	☐ ☐	Yellow Jaundice
☐ ☐	Congenital Heart Disorder	☐ ☐	Heart Trouble/Disease				

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.

Physician's Name _____ Phone number _____

Patient Dental History

Reason for This Visit ? _____

When was your last Dental Visit ? _____ What was done then ? _____

Are you experiencing any dental problems now? ☐ Yes ☐ No _____

Do you clench or grind your teeth? ☐ Yes ☐ No _____

Do you have pain, clicking or popping in your jaw joint ? ☐ Yes ☐ No _____

Do you have any sensitivity to hot, cold, sweets, biting, etc... ☐ Yes ☐ No _____

If you could change anything about your smile, what would you change:

☐ Whiter Teeth ☐ Close Spaces ☐ Straighter Teeth ☐ Repair Chips ☐ Change Shape of Teeth

Have you had any of the following: ☐ Orthodontic Treatment ☐ Periodontal Treatment ☐ Oral Surgery

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 complete of this form. I acknowledge that I have received and read a copy of the Notice of Privacy Practices Sheet and the Financial and Appointment Policy Sheet. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payer and/or healthcare practitioners. I understand that my insurance carrier may pay less than the actual bill for rendered services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents behalf.

Patient's Signature _____ Date _____

BioDental Healing

1000 Newbury Rd. Ste. 225 | Newbury Park, CA 91320

Notice of Privacy Practices

All information that is obtained from you by Centers for Healing is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Per your verbal request, your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations - only.
- Your protected health information can be disclosed without your written authorization in certain limited circumstances such as: medical emergencies, in situations required by law, individuals involved in your care, when requested by public health agency, and when requested by a law enforcement agency.
- For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

_____

Patient's Signature

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Financial and Appointment Policy Sheet

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their dental treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you an estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan prior to initiating treatment. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Fees are due when services are rendered. Although restoration treatment may take several appointments, fees are due at the first appointment when treatment is initiated. BioDental healing no longer offers in-house financing. Balances are discouraged, and must be cleared before the next appointment for any account family member. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances.

A returned check fee of $50.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $50.00 fee plus full payment for the check that did not clear must be paid in cash or credit card. Per history of returned check, the office will no longer accept checks from the patient/account.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. For general dental appointments, **we request 48-hour notice for rescheduling your appointment**; your account will be charged a broken appointment fee of $75.00 for repeatedly missed appointments without proper notification. For dental appointments under IV conscious sedation, we request One Week notice for rescheduling/cancelling your appointment; your account will be charged a broken appointment fee of $1000.00 for the missed appointment without proper notification.

A Cash Courtesy discount of 5% will be applied for paying with cash or check. It is NOT applied with debit or credit cards.

Any credit owed to the account holder/patient will be issued at the end of every month per the account holder/patient's written request. If the written request is not given the monies owed to the account holder/patient will be shown as a recurring credit on the account. Any other questions or special arrangements please contact our office 805-375-2233.