Welcome to The Dentists' Office

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all you dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (CONFIDENTIAL)

Date_____

NAME (First)_____(Last)_____ Birthdate_____ Home Phone_____

Address_____ City_____ State/Zip_____

Email (optional)_____ Cell Phone_____ Soc. Sec. #_____

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

Patient's Employer_____ Work Phone_____

Business Address_____ City_____ State/Zip_____

Spouse or Parent/Guardian's Name_____ Work Phone_____

Spouse or Parent/Guardian's Employer_____ City_____

Whom May We Thank for Referring You?_____

Person to Contact in Case of Emergency (living in same home)_____ Phone_____

Person to Contact in Case of Emergency (not living in same home)_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Email (optional)_____ Cell Phone_____

Driver's License #_____ Birthdate_____ SSN_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? ◯ Yes ◯ No Are there other family members? ◯ Yes ◯ No

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ MasterCard ☐ Care Credit

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ DateEmployed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

DO YOU HAVE ADDITIONAL INSURANCE? ◯ **Yes** ◯ **No** **IF YES, PLEASE COMPLETE THE FOLLOWING:**

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN_____ Date Employed_____

Name of Employer_____ Union or Local #_____ Work Phone_____

Address of Employer_____ City_____ State/Zip_____

Insurance Company_____ Group #_____ Policy ID #_____

Insurance Co. Address_____ City_____ State/Zip_____

Patient's Medical History

Patient's Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes	◯ No	◯ N/A	_____
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	◯ N/A	_____
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	◯ N/A	_____
Are you taking any medication, pills, or prescription drugs?	◯ Yes	◯ No	◯ N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	◯ N/A	_____
Are you on a special diet?	◯ Yes	◯ No	◯ N/A	_____
Do you use tobacco?	◯ Yes	◯ No	◯ N/A	_____
Do you use controlled substances?	◯ Yes	◯ No	◯ N/A	_____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other (Please specify) _____

Do you have, or have you ever had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

*Condition may require medication. N/A – Not answered by patient

Have you ever had any serious illness not listed above? ◯ Yes ◯ NO ◯ N/A If yes, please specify _____

Comments: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

Signature of Patient, Parent or Guardian Date

DENTAL HISTORY

Name: _____
First Last

Please check any of the problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches. Neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad Breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial Denture
- ☐ Braces
- ☐ Periodontal (Gum) Treatments/Deep Cleaning

Please share the following dates:

Your last Cleaning: _____/_____
Your last oral cancer screening: _____/_____
Your last complete X-rays: _____/_____

Name of Previous Dentist:

_____

City: _____State:_____

Phone Number: (_____) _____

General Anesthesia Questions: (required)

Height:_____ Weight:_____
Have you ever had any unusual reactions or complications to medications or anesthesia?
◯Yes ◯No **If yes, please explain below:**
_____
_____
_____

Are you interested in whiter teeth?
◯Yes ◯No ☐I would like more information.

Do you smoke or use chewing tobacco?
◯Yes How much:_____
How Long: _____
◯No

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

Have you ever had Nitrous During dental procedures?
◯Yes ◯No

On a scale of 1-10 with 10 being the highest rating:
How important is your dental health to you?
◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10
Where would you rate your current dental health?
◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Have you ever had a negative or bad experience in a dental office?
◯Yes ◯No Please explain:
_____
_____

Why did you leave your previous dentist?
_____
_____

What is the most important this to you about your dental visit?
_____
_____

EMERGENCY CONTACT NOT RESIDING WITH YOU

Name: _____

Relationship:_____

Phone #: _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect 9/28/17 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Notice of Privacy Practices (continued)

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information.

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notice of Privacy Practices (continued)

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment
You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Add the following sections only if you engage in these activities or may in the future:

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required as approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Patient Rights (continued)

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Tara Hills Dental

Telephone: 510-724-7474 Fax:510-724-7921

Email: info@tarahillsdental.com

Address: 1500 Tara Hills Drive, Pinole, CA 94564

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feriel El Ghaoui, DDS complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____[full name], have received a copy of the Tara Hills Dental Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Feriel El Ghaoui, D.D.S. has been practicing dentistry in Pinole since 2010. We strive to make your dental visits as comfortable as possible. We're never too busy to meet new friends! Here is what you can expect on your first visit:

We'll take time to know you, as well as your likes and dislikes regarding past dental care. We'll carefully review your medical history. We will screen for oral cancer and periodontal (gum) disease. From there. We will examine your teeth and take any necessary x-rays and photos. We will work together to establish a treatment plan that best meets your needs.

Please assist us by providing the following information at the time of your visit:

- Any current X-rays (taken within the last year). You may also provide us with the name and phone number of your previous dental office so we may contact them to have them email electronic x-rays and patient history.
- A list of medications you are currently taking.
- If you have dental insurance, bring your insurance card or documentation.

CONSENT FOR TREATMENT

I hereby grant authority to Feriel El Ghaoui, D.D.S. to administer necessary x-rays, anesthetics or sedative and to perform such operations as may be deemed advisable in their diagnosis and treatment.

I hereby state that the medical and dental histories are correct to the best of my knowledge. I authorize routine dental diagnostic procedures. I also agree to the use of anesthetics and medication considered necessary or advisable by the dentist or her supervised staff. I understand I am responsible for any collection fee/costs if it is necessary for my account to be sent to a third-party collection agency. I understand that it is a courtesy of the dental office of Feriel El Ghaoui, D.D.S. to call my insurance for benefits but it is ultimately my responsibility to verify all information before any dental visit.

I understand the consequences of **NOT** having the needed dental treatment completed.

Dental Materials Fact Sheet

I acknowledge I have received or reviewed a copy of the Dental Materials Fact Sheet dated May 2004 from Tara Hills Dental.

X_____ _____

Patient or Responsible Party Signature Date

Payment is due when services are rendered. Thank you!

FINANCIAL POLICY

Deductibles and estimated patient portions are due at the time of service. The estimated patient portions are based on information provided by your insurance company. If there is any portion due after your insurance payment, you will receive a statement to send in the additional amount owed.

Major treatment procedures, requiring more than one visit, i.e., crowns, bridges, partials or dentures, we will ask for half the fee at the first appointment and payment in full by the time of completion. Regardless of insurance coverage, you are ultimately responsible for payment for treatment.

If the balance becomes 90 days delinquent and is not resolved, your account will be turned over to a third party for Collections with a $35 collection fee added to the account balance. Please remember the contract of coverage is with your insurance company rather than with Tara Hills Dental. **Please notify us of any changes to your insurance.** If not notified, we will use the current information on file to bill your claims.

In our commitment to provide the highest quality dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

Please Check one of the following:

☐ **PERSONAL CREDIT CARDS**	☐ **PREPAYMENT**
☐ VISA ☐ MasterCard ☐ Discover	We are happy to offer a 5% discount (3% credit card) for services over $1000.00 when prepaid in full upon scheduling your appointment.

We are pleased to offer financing options which are administered for us by

☐ **CARE CREDIT**

Please ask our administrative team for details and credit applications.

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.	We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes-complicated task.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment this is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month (18% per year) will be charged to accounts 60 days from treatment date.

MISSED APPOINMENTS

Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule that appointment and you may be charge a fee. If for any reason you should need to change your appointment, there will be no charge, provided, you give 48-hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Signature (responsible party) Financial Coordinator Date

Submit