

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 _____ 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 _____

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?

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



TARA HILLS DENTAL

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!

OFFICE POLICIES

EXPECTED PAYMENT: We deliver the finest care at the most reasonable cost to our patients, we ask that payment be made at the time of service. For your convenience, we accept checks, money orders, credit card (MasterCard, Visa, and Discover).

FINANCING OPTIONS: We are pleased to offer financing options which are administered for us by CareCredit with 6 or 12 month interest free financing upon approval.

DENTAL INSURANCE: We are happy to file your insurance claims to assist you in receiving the full benefits of your coverage. Please notify us of any changes so that we may file your claims accurately. We request you familiarize yourself with your insurance benefits. Please remember that your insurance is a contract between you, your employer and the insurance company ; therefore we can not guarantee any estimated coverage.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

PAST DUE BALANCES: Payment of any past balance is required to be paid in full before incurring new charges. All balances over 60 days are subject to a finance charge of (1.5%) per month or (18%) per year. 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.

CANCELLATION NOTICE: If you are unable to keep your appointment that has been reserved for you, we request you provide us with 48 hour advance notice. Please help us serve you better by keeping your scheduled appointment. Failed appointments are subject to a **\$75.00** fee for routine cleaning appointments and **20% of the total** fee for deep cleaning and appointments scheduled with the Doctor.

We request that you provide a valid credit card number with expiration date to be held and stored according to HIPAA security and privacy regulations in your patient file. Credit card will be charged the according fee for "No Show" or any cancellation made less than 48 hours of your appointment.

CREDIT CARD INFORMATION

Card Type: MasterCard VISA Discover

Cardholder Name (as shown on card):

Card Number:

Expiration Dtae (MM/YY):

Signature (responsible party)

Financial Coordinator

Date
