Jim Alderete, DDS
2820 Daubenbiss Ave., Soquel, CA 95073
831 688-3930

PATIENT INFORMATION

Name ____ Soc. Sec. #______-____-______ Date ______/______/________

Address ____ City____________________________ State___ Zip________

Home Phone (   )________________ Cell Phone (   )________________ Work Phone (   )__________________

Email Address ____

Sex: M ___F___ Age_________ Birth date____/____/_______ Single____ Married____ Divorced____ Partner_____

Name of Spouse/Partner __________________________

Patient employed by ___________________________________ Occupation ___________________________________

Business Address ____

Notify in case of an emergency____ Phone (   )_________________

Whom may we thank for referring you? ____

PRIMARY INSURANCE

Subscriber Name _________________________Relation to Patient ___________ Subscriber D.O.B.____/____/________

Employer Name __________________________________ Employer Address ____________________________________

ID # ____________________ Group # _____________________

Address *(if different from patient)* ________________________________ Phone ____________________

City ____ State________ Zip __________

Insurance Company ____ Phone ____________________

Insurance Address ____ City __________________ State ___ Zip______

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? No☐ Yes☐

Subscriber Name _________________________ Relation to Patient__________ Subscriber D.O.B.____/____/________

Employer Name __________________________________ Employer Address ____________________________________

ID # ____________________ Group # _____________________

Address *(if different from patient)* ____ Phone _____________________

City ____ State __________ Zip________

Insurance Company ____ Phone _______________________

Insurance Address ____ City __________________ State ___ Zip ______

DENTAL HISTORY

Name: ____ Todays Date: ____________________________

What would you like us to do today? ____________________________ Are you experiencing dental pain today? ______

Former Dentist __________________ Address __________________________________ Phone ___________________

Date of last dental care_____________________________ Date of last X-rays __________________________________

Check if you have had problems with any of the following:

Loose teeth or broken fillings No☐ Yes☐	Sensitivity when Biting No☐ Yes☐	Periodontal Treatment No☐ Yes☐
Sensitivity to Cold or Hot No☐ Yes☐	Sores or growths in mouth No ☐ Yes☐	Bleeding gums No☐ Yes☐
Grinding or clenching teeth No☐ Yes☐	Bad Breath No☐ Yes☐	Root Planing No☐ Yes☐
Food collection between teeth No☐ Yes☐	Sensitivity to sweets No☐ Yes☐	Clicking or popping jaw No☐ Yes☐

How often do you brush? ________________________ How often do you floss? ________________________________

Do you use toothpicks, Waterpic, Proxabrushes, Soft Picks or other dental aids? List: _____________________________

Do you like the appearance of your teeth? No☐ Yes☐ Have you ever had a bad dental experience? No☐ Yes☐

Do you smoke or chew tobacco now? No☐ Yes☐ Have you ever used tobacco in the past? No☐ Yes☐

Other information about your dental health or previous treatment ____

Have you ever had a bad reaction to anesthetic? No☐ Yes☐ Explain ____

MEDICAL HISTORY

Physician's Name____ Phone _____________________

Are you taking any medication? No☐ Yes☐ Please list ____

Are you allergic to medication? No☐ Yes☐ Please list ____

Are you allergic to metals or jewelry? No☐ Yes☐ Please list ____

Have you ever had an illness we should be aware of? ____

Are you pregnant? No☐ Yes☐ Do you have a disease or problem not listed?: _________________________________

Have you been diagnosed or had any of the following?

No☐ Yes☐ Anemia	No☐ Yes☐ Diabetes	No☐ Yes☐ Heart Trouble	No☐ Yes☐ Pacemaker
No☐ Yes☐ Allergies	No☐ Yes☐ Heart Murmur	No☐ Yes☐ HIV/AIDS	No☐ Yes☐ Psychiatric care
No☐ Yes☐ Arthritis	No☐ Yes☐ Heart Valves	No☐ Yes☐ Kidney Disease	No☐ Yes☐ Radiation Treatment
No☐ Yes☐ Artificial Joints	No☐ Yes☐ Hepatitis	No☐ Yes☐ Liver Disease	No☐ Yes☐ Rheumatic Fever
No☐ Yes☐ Asthma	No☐ Yes☐ Hemophilia	No☐ Yes☐ Leukemia	No☐ Yes☐ Seizures/Stroke
No☐ Yes☐ Blood Transfusion	No☐ Yes☐ High Blood Pressure	No☐ Yes☐ Latex Allergy	No☐ Yes☐ Thyroid Disease
No☐ Yes☐ Cancer	No☐ Yes☐ Head Injury	No☐ Yes☐ Mitral Valve Prolapse	No☐ Yes☐ Tuberculosis
No☐ Yes☐ Chemotherapy	No☐ Yes☐ Herpes/Cold Sores	No☐ Yes☐ Osteoporosis	No☐ Yes☐ Venereal Disease

I acknowledge that I have received and read a copy of the **Informed Consent for Dental Treatment**, **Notice of Privacy Practices Sheet**, **Written Financial Policy** & the **Facts About Dental Materials** brochure.

Patient Signature: ________________________________ Date: ________ **Reviewed by Dr**: _________ Date: _______

To be taken in office: Blood Pressure: ________/________ Pulse: ______ Date_______________

Left Wrist Taken by:

Informed Consent for Dental Treatment

1. The undersigned hereby authorize Dr Jim Alderete to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize the doctor to perform all mutually recommended treatment agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ___________________________. I understand that using anesthetic agents embodies a certain risk. I also authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in the office for my dependents or myself is mine, due and payable at the time of service unless other arrangements have been made in advance. If payments are not received by the agreed upon dates, I understand that a 1-1/2 % finance charge (18% APR) may be added to my account, in addition to any collection charges.

4. I understand that credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient____ Date_______________ Witness________________

Parent Or Responsible Party _____________________________ Relationship to Patient_________________

For Office use only: Reviewed by Dr.________________________________ Date______________________

Written Financial Policy

Thank you for choosing Dr Jim Alderete. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is to make the cost of your care as easy and manageable as possible by offering several payment options.

Payment Options You Can Choose From:

Cash, Check, Visa, MasterCard, American Express or Discover Card

- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of $500 or more.

Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card

- Allows you to pay over time
- No annual fees or pre-payment penalties

Please note:

Dr Alderete requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.[2]

A fee of $50 is charged for patients who miss or cancel their appointment without 24-hour notice.
The charge for returned checks is $25.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you need.

______________________________ ____________________

Patient, Parent or Guardian Signature Date

[1] Subject to credit approval
[2] However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

<u>Notice of Privacy Practices</u>

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All information that is obtained from you by this office 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.
- 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.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- 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. *

* Conditions and limitations may apply; obtain additional information from the front desk.

Please sign and date the above forms and read <u>The Facts About Dental Materials</u> brochure.