Smile with Confidence

Santa Cruz Family Dentists

Welcome to our Practice!

Will you please help us by providing us with the following confidential information?

PATIENT INFORMATION:

E-mail Address: ______________________________, Last Name: ___________________________________ First Name: ____

Preferred to be called: ____________________________, Street Address: ____

City, State: ____ Zip:___________________ Date of Birth: _______________________________________

Cell Phone: ___________________________________ Work Phone: ____________________________________ Home Phone: ___________________________________

SS#: _______________________________, Driver's License: _________________________________ Sex: __M_____F_ Occupation: _______________________________

Employer: ____, Address, City State, Zip ____

Emergency Contact Name: ____ Relationship: ____________________ Phone # : ____________________________

Spouse's Name: ____ Occupation: ____

Spouse's Address (if different than above): ____, City, State, Zip: ____

Spouse's Employer: ____ Address, City, State, Zip: ____

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

Phone number: ____, Place____ Time: ________________

How did you hear about our office? Please check: _____Internet ____Patient referral ____Website ____Yellow Pages ___Mailer Other __________________________________

If you were referral whom may we thank for their trust in us? ____

DENTAL INSURANCE INFORMATION:

Primary Insurance Company : ____ Address: ____

City: ____ State: ________________ Zip: __________________ Phone #: ______________________________________

Policy Holder Name: ____:Member's ID# ____ Birth date: _______________

Group# or Policy # ____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Santa Cruz Family Dentists of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: ___________________________ Patient's Signature: ____

CONSENT:

I hereby authorize Santa Cruz Family Dentists to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Robert Matiasevich Jr. to make a thorough diagnosis of the patient's dental needs. I also authorize Santa Cruz Family Dentists to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Santa Cruz Family Dentists and your insurance company. I fully understand that it is my responsibility only for all dental treatment regardless of insurance coverage.

____ ____________ ____

Signature of patient or responsible party Date Dentist's Signature .

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48 HOUR RESCHEDULING/CANCELLATION POLICY

When you make an appointment, we reserve that time exclusively for you. For that reason, if you must change your appointment time we request that you provide us with at least **2 business days notice**. A cancellation fee of $100 will be added for all missed or cancelled appointments with **less than 2 business days notice.** We do understand things come up, schedules change and illnesses happen and we will handle each case of missed appointments on an individual basis.

I have read, understand, and agree to the above office policy concerning rescheduling appointments

____ ______________
Signature of patient/ Parent or Guardian of patient Date .

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, ____________________________, have received a copy/explanation of this office's Notice of Privacy Practices.

_______________________________ (Date}__________________
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: ______________________

Our Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

Patient's Role
As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.
So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 30 **days.**

WE ACCEPT CASH, CHECKS OR VISA, MASTERCARD & DISCOVER CARD. Ask us about EASY PAY OPTIONS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Dr. Robert Matiasevich Jr. must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Dr. Robert Matiasevich Jr. I give consent for any credit check to be completed by Dr. Robert Matiasevich Jr. should it be deemed necessary.**

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

_____________________________________ __________ _____________________________________ __________
Signature of patient or responsible party Date Witness for Santa Cruz Family Dentists Date .

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MEDICAL HEALTH HISTORY

PATIENT NAME: ___________________________________
Best Contact Number:______________________________

Name of your physician: _______________________________ Phone Number: ____________________

Date of last medical exam: ______________________

- Have you ever been told by a physician or dentist that you need to pre-medicate prior to any dental appointments? **YES** or **NO** If Yes, please explain:
  ____
- Please list all medications you are currently taking, including the reason(s) why:
  ____
  ____
- Are you Diabetic? **YES** or **NO**
- Do you have High_Blood_Pressure? **YES** or **NO**
- Do you have a Chemical Dependency? **YES** or **NO** If Yes, please explain:
  ____
- Please list any heart conditions you currently have or have had in the past:
  ____
  ____
- Do you have Artificial Joints? **YES** or **NO** If Yes, please explain:
  ____
- Tobacco in any forms? **YES** or **NO** If Yes, please explain:
  ____
- **(FOR WOMEN)-**Are you, or could you be pregnant? **YES** or **NO** Are you nursing? **YES** or **NO**
- Please list all other diseases or medical issues you currently have or have had in the past:
  ____
  ____

Are you allergic or have you reacted adversely to any of the following (Please circle all that apply):

-Penicillin -Amoxicillin -Ibuprofen -Erythromycin -Codeine -Latex -Sulfa Drugs

-Acetaminophen/Tylenol -Barbiturates

-Other Allergies Please list: ____

Circle any of the following that you HAVE HAD or HAVE at present:

-Diabetes -Pacemaker -AIDS or HIV -High Blood Pressure -Stroke or Heart Attack

-Heart Disease -Heart Murmur -Asthma -Hepatitis A B C -Thyroid -Drug Addiction

-Hemophilia -Artificial Joints

Patient Signature: ____ **Date:** ______________________

Doctors Signature: ____

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DENTAL HEALTH HISTORY

Name of your Former Dentist: ____

How long since you were last seen? ____

- What brought you in to see us today? ____

  ____
- Is keeping your teeth important to you? **YES** or **NO**
- Does having dental treatment make you afraid or nervous? **YES** or **NO** If Yes, please explain:

  ____
- If you could change ANYTHING about your smile, what would it be? ______________________________

  ____
- In order for us to provide you with exceptional quality of care we would like to get to know you a little better. These are all important to us as a provider but what is the most important value to you?
  - *Cosmetic*
  - *Function*
  - *Comfort*
  - *Longevity*
- When considering having treatment done which of these would be a concern to you?
  - *Fear*
  - *Time*
  - *Budget*
  - *No sense of urgency*
  - *No trust*
- What is the most important quality for you in a relationship with a doctor?
- Are you a patient who needs detailed information or bottom line information?

Patient Signature: ______________________________ Date: ____________

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