

W E L C O M E

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |
- How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes, list all:

Does patient have drug allergies? If yes, list all:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

**PATIENT ACKNOWLEDGMENT RECEIPT OF
DENTAL MATERIALS FACT SHEET AND
OFFICE CANCELLATION POLICY**

I, _____, acknowledge I have received
from

(Patient Name)

SF Cosmetic Dental Group a copy of the Dental Materials Fact Sheet dated October 2001. I am also aware that if I do not give *San Francisco Cosmetic Group* **two business day's notice** for any scheduled appointment I cannot keep, I will be charged for the time reserved.

Patient

Signature:

Date: _____

The Facts About Fillings:

By the Dental Board of California, 1432 Howe Ave., Sacramento, CA 95825 and at www.dbc.ca.gov

What About the Safety of Filling Materials Used in this Office?

The primary goals of California dental professionals and the Dental Board of California is patient health and safety of dental treatment. This fact sheet will provide you with the information concerning the benefits, advantages and risks of the dental filling materials placed in this office. These facts are, by law*, to be made available to every licensed dentist and to every patient once before beginning any dental filling procedure. We strongly encourage you to read and openly discuss the facts presented here with us if you have any questions regarding the filling materials that will be used in your teeth in our office.

*Business and Professions Code 1648.10-1648.20

Allergic Reactions: Like any other materials we come in contact with every day of our lives, dental fillings may have side effects or cause allergic reactions. The risks are very low for all types of filling materials. Usually, the first signs of an allergy will be a skin rash or itching and can be easily reversed with over the counter medications and discontinued contact of the material with the patient. There are no documented cases of allergic reactions to composite resin, glass ionomer, resin ionomer, or porcelain. These are the only dental fillings we offer in our office. If you suffer from allergies, you may wish to discuss the filling material that will be used with the doctor before placement.

Toxicity: Dental Amalgam. Mercury in its elemental form is on the State of CA's Proposition 65 list of chemicals known to cause reproductive toxicity and may harm the developing brain of a child or fetus. This has caused most of the discussion about the risks of dental restorations. The Food and Drug Administration and other public health organizations have investigated the safety of dental amalgam used in dental fillings and come to the conclusion that there is no valid scientific evidence that has shown amalgams cause harm to patients with dental restorations, unless the patient has a rare case of allergy to amalgam. The World Health Organization has reached a similar conclusion. There are no restrictions on the use of dental amalgam at this time. However, to be overly cautious and avoid any vapor exposure to mercury, we do not use or have dental amalgam in our office.

Composite Resins can include crystalline silica, which is on the State of California's Proposition 65 list of chemicals known to the state to cause cancer. If the material becomes air-borne and is breathed in, it can be a concern. All dental compounds of composite resins are contained in a syringeable paste until they are cured or hardened by light energy and/or chemical bonds. Composite resin fillings are a mixture of powdered glass and plastic resin, commonly referred to as white, plastic or tooth-colored fillings. It is used for fillings, cores, inlays, veneers, partial and complete crowns or to repair portions of broken teeth. It is a strong and durable restoration. It is tooth colored and is placed in a single visit. It resists breakage and preserves the maximum amount of natural tooth surface as it is bonded to the tooth. It does not corrode and resists leakage when bonded to enamel. It has good strength that holds up to most people's biting forces for the life of the restoration. Some products contain fluoride which helps the tooth be more resistant to future decay. The disadvantages include the symptom of tooth sensitivity in some teeth that are still alive or vital (not applicable to teeth after root canal treatment or retreatment). Composite material costs more than amalgam, it wears faster than dental enamel and amalgam, it can leak over time if not sealed with a permanent crown covering the buildup or filling. For this reason, we recommend a crown or other long term stronger restoration be placed over the composite buildup directly after root canal treatment.

Glass Ionomer Cement is a self-hardening mix of glass and organic acid. It is tooth colored and varies in translucency. It is usually used for small fillings and added to materials placed against the gingival/ subgingival soft tissues. It is mixed as a hybrid filling material with resin-ionomer cement in materials used to repair perforations and tooth structure against the periodontal tissues and bone. Resin ionomer cement is a mix of glass and resin polymer and organic acid that hardens with exposure to blue light. Both these materials make the tooth more resistant to decay as they contain and release fluoride. They bond well to both enamel and dentin and allow for minimal amount of natural tooth removal. They are used in non-biting areas but they do not wear as well as other metallic materials or composite materials and so are sometimes mixed with composite materials to give them better longevity. They are more costly than amalgam, like composite, but are esthetic and are usually completed in a single visit. They are, with MTA, amongst the most biocompatible materials for placement against bone and periodontal ligament tissues for repair of holes in roots under the gum.

At times when there is minimal remaining tooth structure to which a buildup and crown need to be attached, the doctor may recommend a metal, stainless steel post be placed within the buildup of the restoration. This gives greater retention than can be gained by bonding forces alone and gives the final restoration a longer life span. Because the post is completely embedded in and under the final restoration, it is completely surrounded by and covered over by bonded or cast dental materials and never is in contact with the oral cavity soft or hard tissues on the exterior of the tooth or teeth. For this reason, the body should never come in direct contact with this inert metal material and this significantly reduces any danger of allergy to this metal material.

San Francisco Cosmetic Group
Nathan G. Roth, DDS. & Aaron E. Rose, DMD.
7 Lombard Street
San Francisco, CA. 94111

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NAME: _____

ADDRESS: _____

TELEPHONE: _____ E-MAIL: _____

PATIENT#: _____ SOCIAL SECURITY#: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICE: You have the right to read out Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment payment activities and health care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include complete consent in the patient's chart.**

San Francisco Cosmetic Dental Group
Nathan G. Roth, DDS & Aaron E. Rose, DMD
7 Lombard Street
San Francisco, CA. 94111

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, 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 the 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.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

TREATMENT: we may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: we may use and disclose your health information to obtain payment for services we provided to you.

HEALTHCARE OPERATIONS: we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provide performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare 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 was in effect, unless you give us written authorization. We cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must 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 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 even of your incapacity or emergency circumstances, we will disclose health information based on the person's involvement in your healthcare. 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, radiographs, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

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 of 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 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 authorize federal office's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENTS 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 using the contact information listed at the end of this notice. 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 to the address at the end of this notice. If you request a copies, we will charge you \$0_____ for each page. \$_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of the notice for a full explanation of our fee structures).

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates discloses your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

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 of location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

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.

ELECTRONIC NOTICE: If you receive this Notice on our website or by electronic mail (e-mail), you are entitles to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or has questions or concerns, please contact us.

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 to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: _____
Telephone: _____ Fax: _____ E-Mail: _____
Address: _____

American Dental Association

All Rights reserved

Reproduction and use of this form by Dentists and their Staff is permitted. Any other uses duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association
This form is educational only, does not constitute legal advice and cover federal, not state law (August 14, 2002).