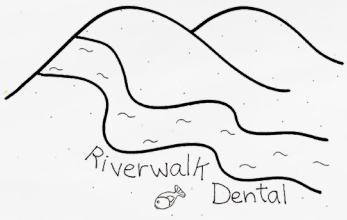
Riverwalk Dental



PATIENT INFORMATION

Name _____ Date of Birth _____ Sex _____ Age _____

Preferred Name _____ Marital Status _____

Address _____ City _____ State ____ ZIP _____

Home Phone _____ Cell Phone _____ Alt Phone _____

E-mail Address _____

Employer _____ Occupation _____

How would you like to be contacted for appointment reminders? 1) Call 2) Text 3) Email

Is it ok to leave voicemail? Yes No If yes, on which phone? 1) Cell 2) Home 3) Both

How did you hear about us? _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship to patient _____

RESPONSIBLE PARTY **(Person responsible for account, if different than above)**

Name _____ Relationship to patient _____

Address _____ Phone _____

INSURANCE INFORMATION

Insurance Company _____ Group Number _____

Subscriber Name _____ Relationship to Patient _____

Subscriber DOB _____ Subscriber SSN/ID _____

Mailing Address _____ City _____ State ____ ZIP _____

HIPAA PRIVACY POLICY

I have been given the opportunity to review the office HIPAA Privacy Policy and I am aware that I have access to a copy at any time.

_____ I have read and understand the office HIPAA Privacy Policy
(Initial)

_____ I have been offered a copy of the office HIPAA Privacy Policy
(Initial)

SIGNATURE

_____ _____
Patient, parent or Guardian Date

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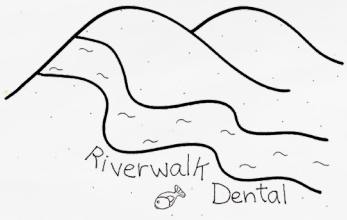

CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct Dr. Claudia Quan, DDS to perform the following dental treatment, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:

- Consult with examination for future treatment
- Preventative hygiene treatment (prophylaxis) and the application of topical fluoride
- Application of sealants to grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
- Replacement of missing teeth with dental prosthesis (ex. Bridges, partials, dentures)
- Removal (extraction) of one or more teeth
- Treatment of diseased or injured oral tissue (hard and/or soft)
- Root canals
- Postponing or delaying treatment at this time

I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me. I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

I will be advised that the success of the dental treatment to be provided will require that the patient and or parents or guardian of patient to follow post care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed, and that the regular office visits scheduled by my dentist and her auxiliaries must be maintained.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I will then be informed of any additional procedures or changes that are deemed necessary for desirable oral health and wellbeing, in the professional judgment of the dentist.

If you are a woman on birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

I understand that the use of local anesthetics carries a small risk for pain, swelling, bruising, tingling and numbness of lips, gums face and tongue, hematoma (swelling or bleeding at/or near injection site), fainting, allergic reaction, lip or cheek biting resulting in ulceration and infection of mucosa, changes in pain perception or prolonged anesthesia. This consent shall remain in effect until such time that I choose to terminate it.

Patient's Name (print) _____ Date _____

Name of Parent or Guardian (minors only) _____

Signature of Patient/Parent/Guardian _____

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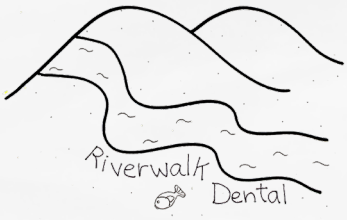

DENTAL HISTORY

Reason for today's visit? _____ Are you currently in pain? ❑ Yes ❑ No

When was your last dental exam? _____ Last dental Cleaning? _____

Are you under stress? (new job, moving, relationships) ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No If no, what would you change? _____

How many times a do you: floss/week? _____ brush/day? _____

Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No

Have you ever had any unfavorable dental experiences? ❑ Yes ❑ No

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

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

___ Bad breath
___ Difficult extractions
___ Bleeding gums
___ Sensitivity to hot
___ Jaw pain/clicking/popping
___ Sensitivity to cold
___ Food collection between teeth
___ Pain with chewing
___ Grinding teeth
___ Sores or growths in the mouth
___ Loose teeth or broken fillings
___ Dry Mouth
___ Gum surgery
___ Head, neck or jaw injury

Here at Riverwalk Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

TOOTH WHITENING • SEALANTS • PARTIALS/DENTURES
CROWN AND BRIDGE • NIGHT/SPORT GUARDS

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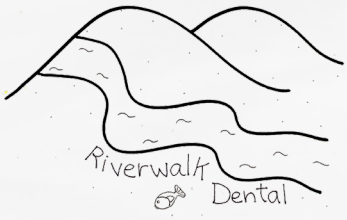

INSURANCE AND FINANCIAL POLICY

Here at Riverwalk Dental, we believe you deserve the best care. That's why we present you with the best dental solution possible for your individual needs. Please read and initial the following:

_____ We will bill your insurance company as a courtesy, but the entire bill is the patient's responsibility. Our insurance estimates are based on information your insurance provider has given us, and they are not a guarantee that your services will be covered. It is up to the patient to resolve any conflicts with their insurance carrier. If the patient is a minor, the custodial parent is legally liable for any bills incurred in this office.

_____ Payment is due at the time of service. If we are billing insurance as a courtesy, we will ask you to pay the estimated patient portion and we will send you a statement if there are any amounts outstanding after receiving payment from your insurance carrier.

_____ We will accept payment of half of the amount of the estimated patient portion for dentures, partials, crowns and bridges on the start date of the procedure. We will collect the second half upon placement or delivery.

_____ Finance charges will be applied to any outstanding balance at months end at the rate of 1.80% per month until balance is paid in full.

_____ We accept cash, check (only for existing patients with established payment history) and all major credit cards. We do not accept checks for amounts greater than $500.00 for any patient. A returned check fee of $30.00 will be added to your balance if your check is returned to us due to NSF (nonsufficient funds). You are responsible for your balance and the returned check fee. If you are in need of extended finance options, we also work with CareCredit, who offers 6, 12, 18 and 24 month finance options.

Patient's Name (print) _____ Date _____

Signature of Responsible Party _____ Date _____

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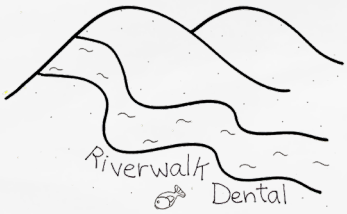

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Print Name (Parent or Legal Guardian) _____

Signature (Parent of Legal Guardian): _____ Date _____

This consent shall be considered in effect until such time I choose to terminate it.

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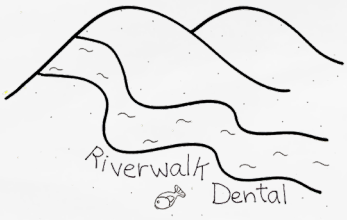

MEDICAL HISTORY

Name _____ Date of Birth _____

Reason for Dental Visit? _____

Drug or food Allergies? _____

If you are unsure of how to answer any of the questions below, please ask dental staff for help.

Do you have or have you had any of the following? Please check (✓)

	YES	NO		YES	NO
*Organ Transplant — Date:			Epilepsy, Seizures, or Nervous System Disease		
*Joint Replacement (hip, knee, ankle, shoulder) — Date:			Stroke		
*Artificial Heart Valve — Date:			Allergy to latex, iodine, or red dye **(circle all that apply)**		
*Congenital Heart Disease, Defect, or Heart Murmur:			Allergy to: metal or local anesthetics **(circle)**		
*Bacterial Endocarditis (SBE)			Cancer/tumors — Dates:		
*Spleen removed			Chemotherapy or Radiation — Dates:		
Steroid Use (e.g. prednisone) — Dates:			Tuberculosis — currently or in past **(circle)**		
HIV or AIDS or believe you've been exposed?			Asthma, or other Lung Disease		
Lupus (SLE)			Ulcers		
Rheumatoid Arthritis			Arthritis		
Diabetes: Type I Type II **(circle)**			Osteoporosis		
Other Immunosuppressive Condition:			Thyroid Problems — High or Low **(circle)**		
Hepatitis — treated in past or currently active			Mental Health Condition:		
Other Liver Disease:			Physical or Mental Disability that requires special consideration:		
Pacemaker / Defibrillator or other Artificial Device / Implant — Date:			Chemical Dependency (alcohol /other drugs)		
Congestive Heart Failure			Do you smoke or chew tobacco?		
Heart Disease or Heart Attack — Dates:			If yes, are you interested in quitting?		
Chest Pain / Angina			Any other disease or condition?		
High Blood Pressure			WOMEN ONLY:		
Have you or are you taking,blood-thinners?			Are you pregnant?		
Anemia or Abnormal Bleeding or Bruising			Are you nursing?		
			Are you taking birth control?		

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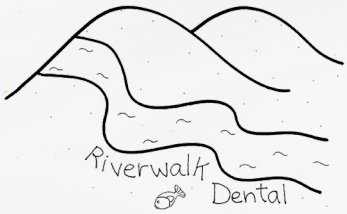

Please circle any of the following medications you have taken (usually for osteoporosis or as part of chemotherapy): IV - Zometa (Zoledronate), IV - Aredia (Pamidronate), IV - Bonefos (Clodronate), Fosamax (Alendronate), Neridronate, Boniva (Ibandronate), Actonel (Risedronate), Didronel (Etidronate), Skelid (Tiludronate), Loron, Olpadronate.

List medications you currently take (including over-the-counter drugs)

_____

Have you ever been hospitalized or had a serious illness? -Yes -No

If yes, when and what for? _____

List all minor and major surgeries you have had _____

Are you currently under the care of a physician? Y/N _____ If yes, for what? _____

Physician Name _____ Physician phone _____

Has your physician ever recommended you take antibiotics prior to dental treatment? Y/N ___

Pharmacy Name _____ Location _____

IMPORTANT! The answers I have given above are true to the best of my knowledge.
I understand that it is my responsibility to update this dental office of any changes in my medical status.

_____ _____

Signature (Patient or guardian if patient is a minor) Date

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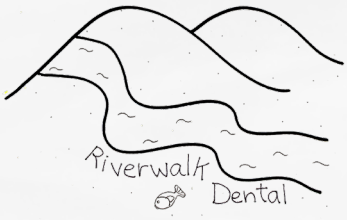

BROKEN APPOINTMENT POLICY

A missed appointment delays your planned treatment and wastes time that could be spent helping another patient. This policy is intended to assure that valuable appointments are used as effectively as possible and you are able to receive the care you deserve.

Patients with three broken appointments within a twelve month period will be eligible for emergency care only for a period of one year after the third broken appointment. An appointment is considered broken if the patient (1) does not show up for the appointment, (2) arrives more that 15 minutes late, or (3) cancels the appointment with less that 24 hours notice.

After one year, the patient may request reinstatement for routine care once again.

Patient Name/Legal Guardian _____ Date _____

Patient/Legal Guardian Signature _____ Date _____

/ / /

REGLA DE CITAS DENTALES

Debido a la alta demanda de citas dentales en Riverwalk Dental, hemos implementado el siguiente reglamento. El proposito del reglamento es para asegurar que las citas disponibles sean usadas efectivamente y que usted pueda recibir el tratamiento que merece.

Si un paciente falta tres citas dentro de un periodo de 12 meses, solo sera elegible para hacer citas de emérgencia dentales por un año comenzando desde la fecha de la tercera cita faltada. Se considera cita faltada (1) si no vienen a la cita, (2) si llegan mas de 15 minutos tarde, o (3) si llaman para cancelar la cita con menos de 24 horas de notificación.

Despues de un año el paciente podra volver a hacer citas para tratamiento dental de rutina.

Nombre del paciente/ Persona a cargo legalmente _____
Fecha _____

Firma del paciente/person a cargo legalmente _____
Fecha _____