Smile By Design

Mountain View Implant Specialist Dr. Donian Shen

PATIENT INFORMATION

Name:

Date of birth: SSN:

Current address:

City State ZIP

Home #: Mobile #:

Work # Email

FINANCIAL INFORMATION

Name of Person Responsible for this Account: Relationship:

Current address:

City State ZIP

Current Patient to our Office?
Yes or No? ____ SSN:

Home #: Mobile #:

Work # Email

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

DENTAL INSURANCE INFORMATION

Subscriber Name: _____

Date of birth: _____ SSN: _____

Insurance Company: _____ Group/Policy #: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Employer Name: _____ Parent Company: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Relationship to Subscriber: _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: _____

Date of birth: _____ SSN: _____

Insurance Company: _____ Group/Policy #: _____

Current address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Employer Name: _____ Parent Company _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Relationship to Subscriber: _____

I, hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that maybe indicated in connection with the dental of the patient above and further authorize and consent that the doctor chooses and employs such assistance as they deem fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or their staff. I agree to pay for all services rendered by this office.

_____ _____ _____

Signature of Responsible Party **Relationship** **Date**

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Patient Name: _____ Date of Birth: _____

Reason for visting our office : _____

Please answer all questions **by checking a box under YES or NO.** (Please do not draw a line.)

Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
☐	☐	High blood pressure
☐	☐	Heart disease from childhood
☐	☐	Heart murmur
☐	☐	Rheumatic fever
☐	☐	Use of Phen-Fen
☐	☐	Pacemaker
☐	☐	Vascular graft
☐	☐	Heart valve replacement
☐	☐	Heart attack
☐	☐	Heart surgery
☐	☐	Congestive heart failure
☐	☐	Angina (chest pain)
☐	☐	Irregular heart beat
☐	☐	Stroke
☐	☐	Increased cholesterol

Endocrine/Hematologic/ Oncologic/Immune:

YES	NO	
☐	☐	Frequent hunger
☐	☐	Frequent thirst
☐	☐	Diabetes Type: _____
☐	☐	Thyroid disease
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Bleeding tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	HIV infection/AIDS
☐	☐	Organ transplant
☐	☐	Blood transfusion

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental:

YES	NO	
☐	☐	Chronic jaw and facial pain
☐	☐	Chronic headache pain
☐	☐	Chronic neck pain
☐	☐	Popping or clicking in your jaw
☐	☐	Joint replacement
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Spinal cord injury
☐	☐	Seizures
☐	☐	Dizziness
☐	☐	Weakness
☐	☐	Multiple Sclerosis
☐	☐	Cerebral palsy
☐	☐	Intellectual Disability
☐	☐	Dementia / Alzheimer's
☐	☐	Fainting spells
☐	☐	Visual impairment
☐	☐	Glaucoma
☐	☐	Hearing impairment

Gastro-Intestinal/Genito-Urinary:

YES	NO	
☐	☐	Hepatitis (A, B, C, or other?)
☐	☐	Kidney dialysis
☐	☐	Ulcers
☐	☐	Sexually transmitted disease
☐	☐	Denied permission to give blood

Psychological:

YES	NO	
☐	☐	Anxiety / Nervousness
☐	☐	Depression
☐	☐	Mental health treatment
☐	☐	Insomnia

OVER PLEASE ↓

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Respiratory:

YES NO

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinus Problems
- ☐ ☐ Night sweats
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis

Other: _____

Social:

YES NO

- ☐ ☐ Do you use tobacco products?
  If so, how much? _____
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day?
  If so, how much? _____
- ☐ ☐ Do you use recreational drugs?

Medication Allergy or Intolerance:

YES NO

- ☐ ☐ Penicillin
- ☐ ☐ Dental anesthetic ("Novocain")
- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Latex products
- ☐ ☐ Iodine

Other: _____

_____

Do you have any medical conditions not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

Family: Did a parent, sibling or child of yours have any of the following?

YES NO

- ☐ ☐ Diabetes
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Cancer

Medications:

YES NO

- ☐ ☐ Are you taking any prescription medicines, any over-the-counter items, or any herbal medicines now?

If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

_____

_____

Do you or have you used bisphosphonate medication (i.e. Fosamax®, Actonel®, Boniva®, Skelid®, Didronel®, Aredia®, Zometa® and Bonefos®) to prevent or treat osteoporosis or as part of a cancer treatment?

YES NO

☐ ☐

Other:

YES NO

- ☐ ☐ Does the amount of saliva in your mouth seem to be too little?
- ☐ ☐ Does your mouth feel dry when eating a meal?

FEMALES ONLY:

YES NO

- ☐ ☐ Are you pregnant now?
  If so, #_____months
- ☐ ☐ Do you take birth control pills?
- ☐ ☐ Are you breast feeding now?

Medical History Updates	Date

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

_____ _____

Signature of patient (or Parent or Guardian if patient is under 18) Date

_____

Reviewed By Date

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Office Procedures

1. **Phone Confirmation:** To cancel your appointment, you must call 24 hours in advance or there is a per hour charge of $50 if you have an hourly appointment.

2. **Verbal Authorization:** It is our office procedure to get verbal authorization from all new patients to confirm appointments and leave messages if patient is not available. Also, patient must call 24 hours in advance to cancel appointments. It also our procedure that we get your insurance information so we can confirm the status of your insurance and get prior authorization for treatment as needed.

Initials: ____

3. I authorize the following person/persons to be **my personal representative**, which means the doctor and staff may speak freely to the named personal representative regarding all my Protected Health Information, Medical and Treatment matters and Billings.

Name	Relationship
_____	_____
_____	_____

_____

Patient's Signature *Date*

4. I authorize the following person/persons **to authorize medical treatment for my named children**. The doctor and staff may speak freely regarding my child/children's Protected Health Information, Medical and Treatment matters and Billings. I understand that I am still responsible for the billing.

Name	Relationship
_____	_____
_____	_____

_____

Patient's Signature *Date*

5. I, _____, authorize *Smile by Design* to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to *Smile by Design*. I authorize *Smile by Design* to release any medical or incidental information and restrictions of my insurance policy, to now which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers that are assigned to me according to my insurance policy rule. It is *Smile by Design's* procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

6. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect Patient Health Information. However, our office was designed before the HIPAA Law, so please be respectful of other patients' privacy.

I, _____, agree to all of the above office procedures of *Smile by Design* and give my authorization to all of the above procedures.

_____

Patient's Signature *Date*

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Acknowledgement of Receipt of Information Practices Notice

I, _____ (Patient's Name), understand that as part my health care , *Smile by Design* originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with an understand that Donian Shen, D.D.S. - Mountain View, CA Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review *Smile by Design* Notice of Privacy Practices prior to signing this acknowledgement.

- *Smile by Design* reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____ Date _____

Printed Name of Individual or Legal Representative Witness _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

_____

_____ _____

Privacy Official Date

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Understanding Dental Insurance

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception: ***dental insurance is not designed to pay for all of your dental care.*** Most contracts have yearly limits, treatment limitations and/or various degrees of "co-payments".

All levels of payment by insurance companies, including allowed fees, usual, customary and reasonable (UCR) are governed by the premiums paid. They have nothing to do with costs, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Thus, there is often a discrepancy between the amount covered under your policy's UCR schedule, and the actual cost of the procedure. The discrepancy is the patient's responsibility.

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral health care and accompanying treatment should not be governed by your insurance company contract.

Thus, it should be understood that ***the dental insurance contract is between the insurance company and the patient***. If you are unclear as to whether a particular procedure is covered by your carrier, please submit a pre-estimate for treatment before scheduling.

We hope this information has been helpful. Please take the time to review your insurance policy's nuances thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

SIGNATURE: _____

DATE: _____

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Financial Agreement

As a condition of your dental treatment in this office, ***financial arrangements must be made in advance***. This practice depends upon reimbursements from the patient and the insurance company for costs incurred in their visit at the time of service. Therefore, the patient must consider their financial obligation prior to the visit.

All dental services including emergency services must be paid at the time services are rendered.

Patients who carry dental insurance must understand that this practice will do our best in preparing your insurance forms or ****assist in making collections from insurance companies*** and will credit any such collections to the patient's account. However, our dental practice cannot render services on the ***assumption*** that our charges will be paid at 100% by an insurance company. Also, this office only accepts benefits from primary dental insurance claims. Claims for secondary insurance are the responsibility of the patient. Insurance claims will be submitted by our office as a courtesy to you; however, you are responsible for the ***total*** payment of your account when insurance ***does not pay the estimated amount.***

A service charge of 1.5% per month (18% annually) on the unpaid balance of any account will be charged to all accounts with balances over 90 days. Any unpaid accounts with balances past 90 days will be turned over to a collection agency and/or an attorney in attempt to collect the remaining payment. All late charges are the sole responsibility of the patient.

Patients must understand that the fee estimate listed is that, an estimate. Treatment plans developed in this practice are subject to change depending the specific dental condition.

ACKNOWLEDGEMENT AND AUTHORITY:

- *In consideration for the services rendered to me by the doctor, I agree to pay in full my estimated portion at the time of service (per the first paragraph). I also agree that I shall be responsible if a remaining balance exists once insurance has paid. I agree to pay all collection costs and attorney fees if a suit shall be suited.*

- *I understand and agree to accept full responsibility for the payment of dental services, in full, at the time of service, unless other arrangements are made before service is provided. This applies regardless of my insurance status. I am aware that under no circumstances will my unpaid balance exceed 90 days from date of service, whether I have insurance coverage or not. In the event of non-payment of balance owed after 90 days, I understand and agree to be charged interest of 1.5% per month.*

- *I have read and fully understand the above conditions of treatment and agree to its content.*

_____ _____

Signature *Date*

*Please realize that we do file your insurance as a ***courtesy*** to you. Any questions/concerns regarding your claim is your responsibility to follow up on. We strive to provide you with timely and efficient service each time you visit our practice and in doing so your assistance is greatly appreciated.

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MOUNTAIN VIEW IMPLANT SPECIALIST DR. DONIAN SHEN

Informed Consent: General Dentistry

1. EXAMINATIONS AND X-RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _____)

2. DENTAL PROPHYLAXIS (CLEANING)
I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials_____)

3. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials _____)

4. DRUGS, MEDICATION AND SEDATION
I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for al least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore,, it is critical that I tell my dentist of all medications I am current taking.

(Initials _____)

5. PREMEDICATION/SEDATION
Premedication/sedation has been prescribed either by my medical doctor (prior to treatment) or by the dentist to perform the treatment required. The instructions, expectations, and precautions have been explained.

(Initials _____)

I give my permission to receive the following as needed for treatment sedation:
☐ Chloral Hydrate Syrup ☐Valium ☐Nitrous Oxide ☐Other: _____ Handout Given (Initials _____)

6. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature _____ **Date:** _____

Doctor: _____ **Date:** _____

☐ **I am refusing radiographs and understand this dental office is unable to offer a comprehensive examination without radiograph. I understand that certain dental or periodontal conditions might go undiagnosed, and cannot hold this office liable for these undiagnosed conditions.**

Signature _____ **Date:** _____