Lunada Bay Dental Practice Dyan Van De Velde, DMD
2325 Palos Verdes Dr. West
Suite 210
Palos Verdes Estates CA
(310)377-6580
Reception@LunadaBayDental.com
LunadaBayDental.com



Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Emergency Contact Person & Phone Number (Specify someone who does not live in your household.)

Reason for Today's Visit:

Whom May We Thank for Referring You?

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Parent/Guardian or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and assign all insurance payments directly to Dr. Dyan Van De Velde, DMD. Dr. Van De Velde may use my health care information and may disclose such information to any Referring Specialist or my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services.

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

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Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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Secondary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Response Date: _____

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Dental History

Patient Name: Last | First | MI | Preferred Name

Former Dentist / City / State:

Date of Last Dental Visit:

Date of Last Dental X-Rays:

Date of Last Dental Cleaning:

How often do you Brush? Floss?

How often do you have your teeth cleaned?

What do you wish you could change about your teeth or smile?

Check below if you have ever had any of the following. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Mouth Pain
- ☐ Dry Mouth
- ☐ Smoker
- ☐ Grinding Teeth

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- [ ] Mouth Breathing
- [ ] Sensitivity to Heat
- [ ] Sensitivity when Biting
- [ ] Burning Sensation on Tongue
- [ ] Clicking or Popping Jaw
- [ ] Food Collection Between Teeth
- [ ] Periodontal Treatment
- [ ] Lip or Cheek Biting
- [ ] Orthodontic Treatment
- [ ] Bleaching / Teeth Whitening
- [ ] Jaw Surgery
- [ ] Sensitivity to Cold
- [ ] Sensitivity to Sweets
- [ ] Blisters on Lips or Mouth
- [ ] Chew mostly on one side of mouth
- [ ] Fingernail Biting
- [ ] Gums Swollen or Tender
- [ ] Jaw Pain or Tiredness
- [ ] Loose Teeth or Broken Fillings
- [ ] Sores or Growths in your Mouth
- [ ] Nightguard

* [ ] By checking this box, I acknowledge that the information provided is true.

Response Date: _____

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Medical History Update

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Please Check Box if Any Medical History of the following apply:

- ☐ Allergies:Other Meds
- ☐ Allergies:Tetracycli
- ☐ Allergy: Codeine
- ☐ Allergy: Latex
- ☐ Allergy: Penicillin
- ☐ Allerigies: Erythro
- ☐ Anemia
- ☐ Anxiety / Depression
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asprin Daily
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleaching
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dimentia / Alzeimers
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epi Sensitivity
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Flouride Gel Carrier
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hearing Loss
- ☐ Heart Murmur/MVP
- ☐ Heart Problems
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Cholesterol
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Niteguard
- ☐ Osteoporosis
- ☐ Other Condition
- ☐ Pacemaker
- ☐ Pregnancy or Nursing
- ☐ Pre-Med
- ☐ Radiation Treatment
- ☐ Rapid Heartbeat
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoker / Tabacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Wheelchair Bound

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Have there been any changes to your health since your last Dental Visit? If yes, please explain.

Have you been in the hospital since your last dental visit?

◯ Yes ◯ No

If YES, please explain:

Please list any current medications you are taking and for what condition:

Please list any additional Medications you are Allergic to:

WOMEN ONLY: Are you pregnant? If yes, when is your due date?

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Response Date:

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

This notice is required by Federal Law and describes how medical/protected health information about you may be used and disclosed and how you can get access to the information.
Once you sign our Patient Registration Consent Form, we may use and disclose your dental record and information in order to treat you, obtain payment, and to operate the practice.
This Notice of Privacy Practices ("Notice") describes the ways we may use and disclose your Protected health Information (PHI) and how you can get access to this information. "Protected Health Information" is information about you that is contained in your dental chart and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future medical, dental or mental health and related healthcare services.
If you have any questions about this Notice, please contact our Privacy Officer.
Uses and Disclosures of Protected Health Information: We may use and disclose your PHI for purposes of dental treatment, payment and healthcare operations as described below.
For Treatment: We may use and disclose your PHI to provide, coordinate or manage your dental treatment and all related services. Examples of how we disclose information for treatment may include sharing information about you with: referring doctors, your primary care physician, a specialist, hospital, pharmacies, and home health agencies.
For Payment: Your PHI will be used and disclosed as required, so that we can bill and receive payments for the treatment and services you have received from us. Examples of how we disclose information to obtain payment include: contacting your dental plan to confirm your coverage or obtain pre-treatment estimates for services to be done in the future, or we may provide information to any other dental insurance plan provider who requests information necessary to collect payment.

For Standard Operations: We may use or disclose your PHI in performing business activities that we call "standard operation". This includes internal operations, such as general administrative activities and to monitor the quality of care you receive while at our facility. Examples include: quality of care assessments, training of staff, assessing certain treatments that we may want to offer in the future, evaluating the performance of employees, licensing, or conducting or arranging other business activities. Examples include: leaving messages on your answering machine, at your place of work, sending emails or other correspondence such as recall notices or billing statements. We may disclose your PHI when making calls to remind you of your appointments. While in the facility we may call you by name.
Other Uses and Disclosures We May Make Without Written Authorization: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your PHI in which you do not have to give authorization. These situations include: those Required by Law, Public Health Information, Public Health Risk Issues, Communicable Diseases, Health Oversight Activity, reporting victims of abuse, Neglect and Domestic Violence, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners, Funeral Directors, research, Criminal Activity and national Security, Inmates/Law Enforcement Custody, and Worker's Compensation in which you do not have to give authorizations. Any Other Use and Disclosure of your PHI requires written authorization: Will be made only with your consent, authorization or opportunity to object unless Required by Law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal PHI. Under federal law, however you may inspect or copy the following records: information complied in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and PHI this is subject to law that prohibits access to PHI.
You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your PHI for treatment, payment, or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for emergency treatment.
You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your dental

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treatment and business in a certain manner and a certain location. For example, you can request that we contact you only on a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.
You have the Right to Request that We Amend Your PHI: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your dental record.
You Have the Right to Request a Paper Copy of This Notice: even if you have agreed to receive this notice electronically, you may request a copy of this Notice at any time by contacting our Privacy Officer in writing or by phone.

You May Issue a Complaint: to our Privacy Officer if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.
We reserve the right to change the terms of this notice of Privacy Practices and to make new provisions effective for all PHI we already have about you as well as any PHI we create or receive in the future. If we make changes, we will:

a) Post the revised Notice in our office, which will contain the new effective date; and
b) Make copies of the revised Notice available to you upon request(either at our office or through the Privacy Officer)

☐ I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Relationship to Patient:

Response Date: