Lunada Bay Dental Practice Dyan Van De Velde, DMD

2325 Palos Verdes Dr. West | Suite 210 • Palos Verdes Estates, CA 90274 (310)377-6580

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

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

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

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employer

_____

_____

Occupation

_____

_____

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?

_____

Parent/Guardian or Responsible Party Information

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

Name: _____ _____ ___ _____
Last First MI Preferred Name

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

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
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.**

Primary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Phone Number _____

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

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

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Phone Number _____

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

☐ **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	☐ Augmenten	☐ Back Problems	☐ Bleaching
☐ Blood Disease	☐ Blood Thinners	☐ CCL Leukemia	☐ Cancer
☐ Chemotherapy	☐ Codeine	☐ Diabetes	☐ Dimentia / Alzeimers
☐ Dizziness	☐ Emphysema	☐ Epi Sensitivity	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Flouride Gel Carrier	☐ Glaucoma
☐ Head Injuries	☐ Hearing Loss	☐ Heart Murmur/MVP	☐ Heart Problems
☐ Hemophilia	☐ Hepatitis B or C	☐ Hernia Surgery	☐ High Blood Pressure
☐ High Cholesterol	☐ IV Contrast	☐ Insomnia	☐ Iodine
☐ Kidney Disease	☐ Latex	☐ Lido/Epi	☐ Liver Disease
☐ Low Cholesterol	☐ Lupus	☐ Mental Disorders	☐ Nervous Disorders
☐ Niteguard	☐ OTHER	☐ Osteoporosis	☐ Other Condition
☐ Pacemaker	☐ Penicillin	☐ Pre-Med	☐ Pregnancy or Nursing
☐ Pregnancy or Nursing	☐ Radiation Treatment	☐ Rapid Heartbeat	☐ Relafen
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Sjogren's	☐ Sleep Apnea Device	☐ Smoker / Tabacco	☐ Spleen Surgery
☐ Spondylo Arthritis	☐ Stomach Problems	☐ Stroke	☐ Strong Gag Reflex
☐ Sulfa	☐ Thyroid	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Wheelchair Bound	☐ keflex	

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 the name and phone number of the pharmacy you use regularly.

_____

_____

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 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: _____

Signature _____ **Date** _____

Response Date: _____

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Financial Policy

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Thank you for choosing us as your healthcare provider. Our goal is to provide quality care in a timely manner. In order to do so, the following policies are to serve as proactive measures to financial obligations.

Proof of Insurance: You are responsible for providing the office with current and accurate insurance information so that we may bill your insurance company within the timely guidelines set forth by your insurance.

Payments of Benefits for Claims: We will bill your insurance company on your behalf. However, you are responsible for all co-pays, deductibles, and any other member liability amounts as determined by your insurance company.

Insurance Coverage: Due to the large amount of insurance plans and policies, it is the responsibility of the patient/responsible party to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of benefits. Furthermore, it is your responsibility to ensure Lunada Bay Dental is participating with your insurance plan. Because insurance coverage varies with each plan, it is your responsibility to be familiar with your plan. Because we are a premier provider practice, it is your responsibility to ensure we are participating with your insurance network.

Usual and Customary Rates: We charge what is usual and customary for the Los Angeles metropolitan area. If we are not contracted with your insurance plan, you are responsible for charges regardless of your insurance company's arbitrary determination of usual and customary rates. We can sometimes offer a discount on out-of-network claims depending on your particular plan.

Non-covered Procedures: You are responsible for any non-covered.

Checks Returned for Non-Sufficient Funds: All checks received for payment of services which are returned by the bank marked "non-sufficient funds" will be charged to you along with a non-sufficient check processing charge of $25.

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

Relationship to Patient: _____

Signature _____ **Date** _____

Response Date: _____