Patient Information (Confidential) **Date: _______**

Patient Name: _____ Preferred Name _____

Birthday: _____ **Soc. Sec #** : _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Cell Carrier (ex: Sprint, Verizon, ATT, etc): _____

Employer: _____ Work #: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Check Appropriate: Minor _____ Single____ Divorced ____ Widowed _____ Married _____

Who may we thank for referring you? _____

Spouse or Parent's Name: _____

Person to Contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Birthday: _____ Soc. Sec. #: _____

Cell Phone #: _____ Home Phone #:_____Driver's License #:_____

Employer: _____ Work Phone:_____

Is this Person Currently a patient in our Office? YES / NO

Primary Insurance Information

Name of Subscriber: _____ Birthday: _____

Relationship to Patient: _____ Soc. Sec. _____

Name of employer: _____ Work Phone:_____ Ext _____

Address: _____ City: _____ State: _____ Zip: _____

Ins. Company: _____ Group #:_____Subscriber ID# _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information

Name of Subscriber: _____ Birthday: _____

Relationship to Patient: _____ Soc. Sec. _____

Name of employer:_____ Work Phone:_____ Ext _____

Address: _____ City: _____ State: _____ Zip: _____

Ins. Company: _____ Group #:_____Subscriber ID# _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY

Please list ALL prescription medication, herbal products and over the counter products you are taking. If you are taking any "street drugs" please list them. Any drug can interact with the medications we administer. Your medical information is private and you health is important.

_____

_____

Do you have any of the following? (Circle Yes or No)

Congenital Heart Defect	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Mitral Valve Prolapse	Yes	No
Joint Replacement	Yes	No	Heart Surgery	Yes	No

If yes, how long? _____ If yes, what type? _____

Antibiotic Pre-Medication- A "YES" answer to any of the above questions may require antibiotic pre-medication or a release form from your physician prior to any dental treatment.

If I require antibiotic pre-medication, I understand and agree it is my responsibility to take the prescribed antibiotics as directed before ANY dental procedure is performed. If I need another prescription for pre-medication I will ask. I understand that failure to take the antibiotic premedication can result in serious medical complications. **INITIAL:** _____

Diabetes	Yes	No	Asthma or Emphysema	Yes	No
Heart Attack	Yes	No	Pacemaker	Yes	No
Abnormal Bleeding	Yes	No	Hemophilia	Yes	No
Cancer/Chemotherapy	Yes	No	Radiation Therapy	Yes	No
Liver Disease/Hepatitis	Yes	No	Kidney Disease	Yes	No
Epilepsy or Seizures	Yes	No	Stroke	Yes	No
Blood Transfusions	Yes	No	HIV+ or AIDS	Yes	No
Anemia	Yes	No	High / Low Blood Pressure	Yes	No
Alcohol Use (2+daily)	Yes	No	Tuberculosis (TB)	Yes	No
Tobacco Use	Yes	No	Thyroid Problems	Yes	No
Hepatitis	Yes	No	Herpes / Fever Blisters	Yes	No
Sleep Apnea	Yes	No	Bisphosphorates	Yes	No

Are you ALLERGIC to any of the following?

Penicillin	Yes	No	Tetracycline	Yes	No	Erythromycin	Yes No
Sulfa / Sulfides	Yes	No	Aspirin	Yes	No	Codeine	Yes No
Dental Anesthetics	Yes	No	Jewelry / Metals	Yes	No	Latex	Yes No

List any other allergies you may have_____

Are you pregnant (women)? Yes No Maybe

Are you under the care of a physician? Yes No
Name and telephone number of Physician: _____
If so, what condition being treated? _____

Have you taken any prescribed diet medication such as Phen-Fen? _____

Please explain any "yes" answers. Also, list any other medical conditions or limitations you may have that are not listed above:

I certify that the information given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up to date information is important for my wellbeing and safety. I understand and agree that it is my responsibility to inform this office of any changes in medical status before my treatment is rendered.

Patient Signature _____ Date _____

Print Name _____

Doctor: _____ Witness: _____

ACKNOWLEDGEMENT OF: RECEIPT OF NOTICE PRIVACY PRACTICES. (HIPAA)

The Health Insurance Portability and Accountability of Act of 1996 (HIPAA) requires that health care providers

give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgment of the receipt of same. You may refuse to this acknowledgment form.

By signing this form, I have received a copy of the Notice of Privacy Practice.

Patient's Name: _____

Signature of Patient or Guardian: _____**Date:** _____

If minor: Relationship to Patient_____

PATIENT ACKNOWLEDGEMENT OF: RECEIPT OF DENTAL MATERIALS FACT SHEET
Our office can provide these documents upon request

I, _____, acknowledge I have received from
(Patient Name)
Image Dental a copy of the dental Materials Fact Sheet dated October 2001.

_____ _____ _____

Patients or Guardians Signature **Date** **Relationship to Patient**

GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: _____

1. **EXAM AND X-RAYS-** I understand that necessary x-rays are required in assisting the dentist provide and perform a comprehensive diagnostic dental exam.

(Initials_____)

2. **DRUGS AND MEDICATIONS-** I 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.

(Initials_____)

3. **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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/ all changes as necessary.

(Initials_____)

4. **REMOVAL OF TEETH-** Alternative to removal has been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ and any other necessary for reasons in paragraph # 3. I understand removing teeth do not always remove all the infection, if present, and it may necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(Initials_____)

5. **CROWNS, BRIDGES, AND CAPS**- I understand that sometimes it is not easy to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap including shape, fit, size and color will be before cementation. **I t is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.**

(Initial_____)

6. **ENDODONTIC TREATMENT (ROOT CANAL**) - I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal fillings material may extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally instruments can become broken or separated during the endodontic procedure and that additional surgical procedures may be necessary following root treatment. I understand that the tooth may be lost despite all effort to save it.

(Initials_____)

7. **PERIODONTAL DISEASE AND BONE LOSS**– I understand that I have a serious periodontal condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth and other serious health conditions. Alternative treatment has been explained to me, including Scaling and Root Planing (Deep Cleaning), gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials_____)

8. **DENTURES AND PARTIALS-** I understand the wearing of dentures or partial dentures are difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extraction) may be painful. Immediate dentures may require considerable adjusting and several relines. Permanent reline will be needed later. This is

not included in the fees. I understand that it is my responsibility to return for delivery of the dentures. **I understand that denture and partials require several dental appointments for impressions, try ins, and delivery of. Failure to keep any of these appointments may result in poorly fitted dentures or partials. If remake is required due to my delays for more than 30 days there will be additional charges.**

(Initials_____)

9. **FILLINGS:** I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling that originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

(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, which 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 neither Dentist nor Dental Group of Stockton is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of Image Dental to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending in unforeseen or undiagnosable that may arise during the course of treatment. **I understand that regardless of any dental insurance coverage I may have, I am responsible for payment dental fees. I agree to pay any attorney's fees, collection fees, or court that may be incurred to satisfy this obligation.**

Should any dispute arise over dental services provided to me, that is whether any dental service rendered allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed, said disputes shall be submitted to Peer Review by the local component of The American Dental Association. The decision of Peer Review photocopy of this authorized shall be as valid and effective as the original forever I am of legal age and legally competent to make this assignment.

Signature: _____ **Date:** _____

Doctor: _____ **Witness:** _____

Appointment Cancellation and No-Show Policy

Image Dental is privileged to provide dental treatment to our patients. We will work diligently to maintain a high level of personalized service and will strive to accommodate our patients' need for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time, just as they do for us; however, when a patient fails an appointment or cancels without adequate notice, we cannot use that time to meet the needs of other patients. We respectfully request your understanding and agreement to our policy as it is stated below.

New Patients:

We will give you a reminder phone call, or text within 48 hours of your scheduled appointment. New patients who fail or cancel initial appointments with less than 48 hours' notice prior to the appointment, will be required to pay a deposit of $50 for a dentist visit and $75 for a specialty dentist visit before rescheduling another appointment. For Monday appointments, cancellations must be made by noon on the preceding Friday. If we do not answer please leave a message.

Established Patients:

Established patients who fail or cancel appointments with less than 48 hours' notice prior to the appointment, will result in a $50 fee for missed dentist visits and a $75 fee for missed specialty dentist visits. The full fee of the treatment will be paid before rescheduling. A third failed appointment will result in dismissal from the practice. For Monday appointments, cancelations must be made by noon on the preceding Friday. If we do not answer please leave a message. The scheduling parent or scheduling legal guardian of minors who fail or cancel appointments with less than 48 hours' notice will be held responsible for the missed appointments.

Fees:

Fees charged by Image Dental pursuant to this policy are not payable by insurance companies.
We ask $50 is paid to reserve appointments that are 2 hours, or longer and $75 to reserve appointments with our specialists. This fee will go towards your dental treatment, however if the appointment is missed, or has not been rescheduled less than the 48 hours of the appointment time the reservation fee will be forfeited and no refund will be given. The full fee of the treatment will be required to reschedule the appointment.

_____ _____

Patient Signature **Date**

_____

Parent/Legal Guardian Signature

FINANCIAL POLICY FOR DR. STEPHEN N. NOZAKI, DDS, MPH

We strive to provide an affordable option to save your teeth. We realize that every person's financial situation is different. Please initial each line and sign at the bottom of this sheet. Thank you for your cooperation!

_____IF YOU HAVE DENTAL INSURANCE. YOUR PRE-ESTIMATED INSURANCE BENEFIT IS NOT A GUARANTEE OF PAYMENT. IT IS ONLY AN ESTIMATE. THE INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND THE INSURANCE COMPANY. YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES.

_____PRE-ESTIMATED CO-PAYMENTS WITH OR WITHOUT DENTAL INSURANCE ARE DUE BEFORE RENDERING TREATMENT. WE RESERVE THE RIGHT TO SEND YOUR ACCOUNT TO COLLECTIONS IMMEDIATELY IF YOU DO NOT UPHOLD THIS POLICY.

_____TREATMENT PROCEDURES ARE SUBJECT TO CHANGE DURING THE TIME OF TREATMENT AND WILL BE REFLECTED IN ANY FEE CHANGES.

_____BENEFITS ARE CALCULATED BASED ON CURRENT AVAILABLE BENEFITS, PATIENT ELIGIBILITY AND ANY PROFESSIONAL COURTESIES. WE MAKE EVERY ATTEMPT TO HELP YOU RECEIVE THE MAXIMUM REIMBURSEMENT TO WHICH YOU ARE ENTITLED.

_____ESTIMATES ARE SUBJECT TO MODIFICATION BASED ON ELIGIBILITY, COORDINATION OF BENEFITS, THE BENEFIT PLAN IN EFFECT AT THE TIME SERVICES ARE COMPLETED AND ANY PROFESSIONAL COURTESIES.

_____AS A COURTESY, WE WILL SUBMIT THE CLAIM TO YOUR INSURANCE CARRIER FOR THE RENDERED PROCEDURES. IF THERE IS ANY REMAINING BALANCE AFTER YOUR INSURANCE PAYS, WE WILL SEND YOU A STATEMENT VIA POSTAL MAIL, WHICH IS DUE UPON RECEIPT.

_____ IF YOU DO NOT AGREE WITH OUR PRE-DETERMINED ESTIMATE, YOU HAVE THE RIGHT TO FILE THE CLAIM TO YOUR INSURANCE CARRIER AND RECEIVE DIRECT PAYMENT FROM THEM. YOU WILL BE REQUIRED TO PAY THE FULL FEE AT OUR OFFICE PRIOR TO TREATMENT.

_____IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH ACCURATE INFORMATION FOR YOUR DENTAL INSURANCE CARRIER(S). INCORRECT INFORMATION WILL DELAY INSURANCE CLAIMS AND PAYMENTS. WE SUBMIT TO YOUR CARRIER AS A COURTESY. IF INCORRECT, PAYMENT IN FULL FOR RENDERED PROCEDURES WILL BE BILLED TO YOUR ACCOUNT AND DUE UPON RECEIPT. YOU WILL RECEIVE A BILL VIA POSTAL MAIL. YOU MAY THEN SUBMIT THE CLAIM YOURSELF FOR REIMBURSEMENT FROM YOUR DENTAL INSURANCE CARRIER.

_____UNPAID BALANCES AFTER 30 DAYS ARE SUBJECTED TO LATE FEES AND CHARGED INTEREST. UNPAID BALANCES WILL BE SENT TO COLLECTIONS AFTER 90 DAYS.

_____RETURNED CHECKS (INADEQUATE FUNDS) ARE SUBJECT TO A $50.00 CHARGE.

_____ _____ _____

Patient (Guardian) Name Print **Signature** **Date**