Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # ____________________

SS#________________________

Welcome to our practice

PATIENT INFORMATION

Name___________________________ Birthdate________________ Home Phone (______)___________________

Address___________________________ City_____________________ State________ Zip ________________

Sex __ M __F __ Married __ Widowed __ Single __ Minor __ Separated __ Divorced __ Partnered for _____ years

E-mail________________________ Cell Phone 1 (_____)_______________ Cell Phone 2 (______)________________

Employer /School ______________________________ Employer/School Phone (______)________________________
Employer /School Address_________________________ City__________________ State ______ Zip ______________
Spouse or Partner Name____________________ Employer___________________ Work Phone (_____)____________

Whom may we thank for referringyou?____
Person to contact in case of emergency___________________________ Phone (_______)______________________

RESPONSIBLE PARTY

Name of Person
Responsible for this Account ____________________ Relationship to Patient ________________________________
Address___________________________________ Home Phone (_____)___________________________________
Driver's License #______________________ Birthdate _______________ Cell Phone (_____)___________________
Currently a patient in our office? __ Yes __ NO E-mail ____

INSURANCE INFORMATION

Name of Insured _____________________________ Relation to Patient _________________________________

Birthdate ______________ Social Security# ______________________ Date Employed _______________________

Employer ____ Work Phone (_____)_______________________

Insurance company ________________________ Insurance Phone number (_____)______________________________

Insurance Address __________________________________ ID #___________________ Grp/union #_____________

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and /or my dependent(s), have insurance coverage with _____________________________________ and
Name of insurance company(ies)
assign directly to Dr. Accettura all insurance benefits, if any, otherwise payable to me for services rendered. 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.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed for one year from the date signed below.

______________________________________ ______________________________
Signature of Patient , Guardian or Personal Representative Date

______________________________________ ______________________________
Please print name of Patient , Parent, or Personal Representative Relationship to Patient

Payment is due at time of treatment. Any unpaid dental benefits are the patients responsibility.

SCHEDULED APPOINTMENT NOTICE

We understand that your time is valuable and sometimes conflicts occur in your schedule. In the event that you may require a change in your appointment time we are happy to accommodate you with a 48 hour notice.

As a courtesy we will call to remind you of your reserved appointment.

For an unseen emergency in your schedule we will provide each patient with one courtesy reschedule. Each missed appointment thereafter will result in a $50 per scheduled hour missed appointment fee.

This charge is not covered by insurance and is each patient's individual responsibility.

Patient Signature_______________________________________

Date_______________

Family Dentistry

Antonia Accettura, DDS, INC.
1233 East Main Street
Grass Valley, Ca. 95945
(530) 273-8646 Fax: (530) 272-1514
www.GrassValleySmiles.com

NOTICE OF PRIVACY PRACTICES

All information obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your health information is practiced.

USES AND DISCLOSURES

1. Your protected health information is accessed and used for healthcare related purposes only.
2. Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes marketing activities without your written authorization.
3. Your protected health information is disclosed to third-party entities without your written authorization for purpose of treatment, to obtain payment for treatment, and for healthcare operations.

CERTAIN CIRCUMSTANCES

Your protected health information can be disclosed without your written authorization in certain limited circumstances.

1. Medical emergencies
2. In situations required by law
3. Individuals involved in your care.
4. When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations or certain circumstances. We will ask for you written authorization to disclose protected health information, you can revoke that authorization in writing at any time.

PATIENT RIGHTS

1. You have the right to request in writing to inspect and/ or receive a copy of your health information.
2. You have the right to request an alternate means or location to receive communications regarding your health information.
3. You have the right to request in writing to amend , correct, or delete any recorded healthy information within our possession
4. You have the right to request in writing to restrict some of the uses and disclosures of your health information
5. You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

**Conditions and limitations may apply; obtain additional information from front desk.*

Changes to this notice: We reserve the right to change practices and the conditions of this notice at any time and without prior notice. In the event of changes, and update notice will be posted and a copy will be sent to you.

I, ____, have had full opportunity to read and consider the contents of you Notice of Privacy Practices. I understand that by signing this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature____ Date_____________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representative's name____
Relationship to the patient ____

I authorize Dr. Accettura and staff to communicate with ____

Spouse/Partner or Guardians

about my protected health care information.

Signature ____ Date ___________________________

You are entitled to a copy of this consent after you sign it.

Dental Health History Form

Today's Date ____________

Patient Name: First ____________ MI ____ Last ____________ Nickname ____________

What are your goals in coming to our practice today? ____________

What is important to you in a dentist or dental practice? ____________

What has been your experience with the dentist in the past? ____________

Date of last radiographs (x-rays) and exam ____________

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* ____________

Former Dentist ____________ Phone ____________

Address: Street ____________ City ____________ State ______ Zip ______

If you left your previous dentist, what are the reasons? ____________

Have you had problems with prior dental treatment? ____________

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe ____________

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If yes, why? ____________

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why? ____________

Would you like to discuss this concern with the doctor to learn about your relaxation options? ____________

What concerns do you currently have with your oral health or smile? *(check all that apply)*

☐ Jaw joint pain
☐ Clenching or grinding of teeth
☐ Discolored teeth
☐ Crowding/Crooked teeth
☐ Missing teeth
☐ Spaces in between teeth
☐ Loose tooth/teeth
☐ Tooth shape or size

☐ Unhappy with appearance of teeth
☐ Overbite
☐ Underbite
☐ Uncomfortable bite
☐ Old fillings *(gold or silver)*
☐ Old crowns
☐ Speech problems
☐ Too much gum tissue when I smile

☐ Tooth sensitivity to hot/cold or anything else
☐ Food gets caught in between teeth
If yes, where? ____________
☐ Difficulty chewing
If yes, where? ____________
☐ Bad breath
☐ Other ____________

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? ____________

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No

If yes, when? ____________

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method? ____________

Are you interested in learning more about the following? *(check all that apply)*

☐ Teeth Whitening
☐ Orthodontic treatment
☐ Veneers

☐ Tooth-colored fillings
☐ Dental implants
☐ How to prevent periodontal disease

☐ At-home oral hygiene care
☐ Periodontal treatment during pregnancy
☐ Oral hygiene care for infants and toddlers

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Notice for Patients with Dental Benefits
Informed Consent

This form was designed to help patients understand their individual dental benefit plans. It is imperative that each individual patient understands that **the dental office does not determine your coverage**. Each patient's benefits are different, possessing different copays, exclusions, limitations and covered treatment.

Dental plans DO NOT cover all procedures. They are usually discount plans, NOT insurance plans. For example, if a patient should crash their car on Monday, fix it Tuesday and crash it again on Wednesday, their insurance would cover the damage, with some individual restrictions. With a dental plan, however, this "coverage" would not be the same. Typically, most dental benefit plans have predetermined restrictions, limiting the frequency and ways in which the plan will reimburse for any services provided in the dental office.

The dental office has no control over the Dental Plan's payments, coverage, exclusions or limitations. The dental plan was not chosen or created by the dental office. The dental plan is completely separate from the dental office and is as accessible to the dental office staff, as it is to each individual consumer of the dental plan. Although we will always try to provide you with an estimate for services, more and more, we are finding that dental benefit plans reject claims after the fact, and leave patients feeling frustrated because they don't know all of the inherent rules, restrictions and limitations of their plans. Please ensure that you have read and understand your individual dental plan's exclusions and limitations.

You and your dentist determine your individual dental treatment needs. The dentist is licensed to diagnose and treat dental conditions based on experience and expertise. Each individual patient is then shown and informed of the findings and solutions available to them. Treatment can often be preauthorized through their benefit plan, however this can take several weeks, and still could result in a denial of benefits. The dental office is unable to anticipate how a third party will reimburse for all services. Each patient MUST be aware that our duty is to provide dental care in the best possible way to achieve oral health. **The dental plan's duties are very different and are NOT centered on patient needs; rather, each plan is governed by predetermined "covered" benefits, exclusions and limitations.**

I have read and understand this consent form and have been informed that all costs incurred are my responsibility. If my dental benefit plan changes, it is my responsibility to inform the dental office prior to treatment. The dental office reserves time for my treatment in advance. The dental office also reserves the right to charge a $50.00 per scheduled hour cancellation fee for any treatment reservations I have made and choose to cancel within 48 hours of my prescheduled appointment. (Monday appointments must be canceled by the previous Thursday morning, as we will be unable to cancel appointments while the office is closed). Any unpaid balances or balances not paid by my benefit plan are my responsibility within 30 days of the billing cycle.

Patient Signature____ Date________________________

Confidential Health History Form

Today's Date________________

Patient Name: First________________ MI____ Last________________ **Date of Birth**________________

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain________________
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain________________
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain________________
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain________________
   Date of last medical exam?____________ **Reason for exam**________________
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain________________
   Date of last dental exam____________ **Name of last treating dentist**________________
6. **Yes / No** **Are you in pain now?**
   If YES, explain________________

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No Chest pain (angina)
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No Heart disease
Yes / No Family history of heart disease
Yes / No Heart attack
Yes / No Artificial joint
Yes / No Stomach problems or ulcers
Yes / No Heart defects
Yes / No Heart murmurs
Yes / No Rheumatic fever
Yes / No Skin disease
Yes / No Hardening of arteries
Yes / No High blood pressure
Yes / No Seizures
Yes / No Cosmetic surgery
Yes / No Surgeries
Yes / No Hospitalization
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Emphysema or other lung disease
Yes / No Kidney or bladder disease
Yes / No Stroke
Yes / No Eating disorders
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Asthma
Yes / No Hepatitis
Yes / No Sexual transmitted disease
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Anemia
Yes / No Liver disease
Yes / No Eye disease
Yes / No Transplants
Yes / No Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV
Yes / No Anxiety
Yes / No Depression
Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No Aspirin
Yes / No Darvon
Yes / No Codeine
Yes / No Latex
Yes / No Local anesthetic (Novocain or Xylocaine)
Yes / No Valium
Yes / No Demerol
Yes / No Penicillin
Yes / No Food
Yes / No Erythromycin
Yes / No Tetracycline
Yes / No Vicodin
Yes / No Percodan
Yes / No Nitrous oxide
Yes / No Metal

Others________________

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Cortico - Steroids				

Please list all medications you are currently taking ______________________________

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** ______________________________
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain ______________________________

____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why ______________________________

Yes / No **Have you ever taken Fen-Phen?**
If YES, when ______________________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature ______________________________ Date ______________

Physician's Name ______________________________ Phone Number ______________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________ ______________ ______________________ ______________
Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials