OSO MARGUERITE DENTAL

Office: (949) 582-6460 **Email:** info@osomd.com
Fax: (949) 582-5991 **Website:** OsoMargueriteDental.com
26932 Oso Pkwy #280, Mission Viejo, CA 92691, USA

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name _____ **Age** _____
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian: _____

Residence Address: _____
STREET CITY ZIP

Patient is: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor

Responsible Party Name_____ **Drivers License No.**_____

Social Security No. _____ Occupation _____

Employed by _____ How Long? _____

Business Address _____
STREET CITY ZIP

Spouses Name _____ Drivers License No._____

Employed by _____ How Long? _____

Business Address _____

Emergency Contact (nonresident)_____ **Relationship** _____

Complete Address _____
STREET CITY ZIP

Name of Physician _____ ( )
STREET CITY ZIP TELEPHONE

Who may we thank for referring you? _____

Patient's Birthday: _____ ❑ Male ❑ Female

Relationship: _____

Patient SS# _____

Res. Phone ( ) _____

Cell Phone ( ) _____

Bus. Phone ( ) _____

Day time Phone ( ) _____

Home Phone ( ) _____

E-Mail Address _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ ( )
STREET CITY ZIP TELEPHONE

Preference of payment: ❑ Check ❑ Cash ❑ Visa/Mastercard

Name of dental primary insurance company _____

SUBSCRIBER NAME BIRTHDAY RELATIONSHIP SOCIAL SECURITY NO.

GROUP NO

Name of second insurance_____

SUBSCRIBER NAME BIRTHDAY RELATIONSHIP SOCIAL SECURITY NO.

GROUP NO

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.All emergency dental services, or any dental service performed without prior arrangements, must be paid for in cash as the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office can not render services on the assumption that charges will be paid by and insurance company.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand that the fee estimate for this dental case can only be extended for a period of six months from the date of the patient examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing of credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally. I agree that a waiver for any breach of any term or conditions hereunder shall not constitute a waiver of any further term of condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or my work to discuss related to this form.I have read the above conditions of treatment and agree to their content.

Signed	**Date**

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

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PATIENT DENTAL HISTORY

Patient Name

Medical Alert

What is the reason for your visit today? _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ ZIP _____ Phone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you require antibiotics prior to dental treatment? ❑ Yes ❑ No

Do you have any dental problems now? ❑ Yes ❑ No

If yes, please describe _____

Are any of your teeth sensitive to:

Hot or Cold? ❑ Yes ❑ No
Sweets? ❑ Yes ❑ No
Biting or Chewing? ❑ Yes ❑ No
Have you noticed mouth odor/bad taste? ❑ Yes ❑ No
Do you frequently get cold sores/blisters? ❑ Yes ❑ No
Do you have any other oral lesions? ❑ Yes ❑ No

Do your gums bleed or hurt? ❑ Yes ❑ No
Have your parents experienced gum disease or tooth loss? ❑ Yes ❑ No
Have you noticed any loose teeth or change in your bite? ❑ Yes ❑ No
Does food tend to become caught in between your teeth? ❑ Yes ❑ No
If yes, where? _____

Do you:

Clench/grind teeth while awake or asleep? ❑ Yes ❑ No
Bite your lips or cheeks regularly? ❑ Yes ❑ No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ❑ Yes ❑ No
Mouth breathe while awake or asleep? ❑ Yes ❑ No
Have tired jaws, especially in the morning? ❑ Yes ❑ No
Smoke or chew tobacco? ❑ Yes ❑ No

Have you ever had:

Orthodontic treatment? ❑ Yes ❑ No
Oral Surgery? ❑ Yes ❑ No
Gum Surgery? ❑ Yes ❑ No
Periodontal Treatment? ❑ Yes ❑ No
Teeth ground/bite adjusted? ❑ Yes ❑ No
A bite plate or mouth guard? ❑ Yes ❑ No
A serious injury to the mouth/head? ❑ Yes ❑ No
If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? ❑ Yes ❑ No
Pain? (joint, ear, side of face) ❑ Yes ❑ No
Difficulty in opening/closing mouth? ❑ Yes ❑ No
Difficulty chewing on either side of the mouth? ❑ Yes ❑ No
Headache, neckache, shoulderache? ❑ Yes ❑ No
Sore muscles (neck, shoulders)? ❑ Yes ❑ No

Would you like to keep all of your teeth your whole life? ❑ Yes ❑ No
Would you like whiter teeth? ❑ Yes ❑ No
Are you satisfied with your teeth's appearance? ❑ Yes ❑ No

Do you feel nervous about having dental treatment? ❑ Yes ❑ No
If yes, what is your biggest concern? _____
Have you ever had an upsetting dental experience? ❑ Yes ❑ No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? ❑ Yes ❑ No
Please describe _____
_____
_____

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PATIENT MEDICAL HISTORY

Patient Name

Medical Alert

Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

If yes, for what? _____

Physician's Name _____

Address _____ State _____ ZIP _____ Phone _____

Name of medications taken the past two years _____

Have you ever taken Fosamax/other bisphosphonate? ❑ Yes ❑ No

If yes, when? _____

Have you ever taken prescription medications for weight loss (diet pills)? ❑ Yes ❑ No

Please circle if you are allergic to any of the following: Aspirin Codeine Dental Anesthetics Erythromycin Jewelry/Metals Latex Penicillin Tetracycline Other

Please list any other drugs/materials that you are allergic to _____

Have you been a patient in the hospital in the past five years? ❑ Yes ❑ No

Reason _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Disease (surgery) ❑ Yes ❑ No	Thyroid Problems ❑ Yes ❑ No	Lupus ❑ Yes ❑ No
Chest Pain ❑ Yes ❑ No	Glaucoma ❑ Yes ❑ No	Colitis ❑ Yes ❑ No
Congenital Heart Disease ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Yellow Jaundice ❑ Yes ❑ No
Difficulty Breathing ❑ Yes ❑ No	Chronic Cough ❑ Yes ❑ No	Liver Disease ❑ Yes ❑ No
Heart Murmur ❑ Yes ❑ No	Tuberculosis ❑ Yes ❑ No	Hepatitis A B C (circle) ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No	Asthma ❑ Yes ❑ No	Venereal Disease ❑ Yes ❑ No
Mitral Valve Prolapse ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	AIDS ❑ Yes ❑ No
Artificial Heart Valve ❑ Yes ❑ No	Allergies/Hives ❑ Yes ❑ No	HIV Positive ❑ Yes ❑ No
Heart Pacemaker ❑ Yes ❑ No	Cancer ❑ Yes ❑ No	Cold Sores/Herpes ❑ Yes ❑ No
Rheumatic Fever ❑ Yes ❑ No	Radiation Therapy ❑ Yes ❑ No	Epilepsy/Seizures ❑ Yes ❑ No
Arthritis/Rheumatism ❑ Yes ❑ No	Chemo Therapy ❑ Yes ❑ No	Fainting/Dizzy Spells ❑ Yes ❑ No
Cortisone Medicine ❑ Yes ❑ No	Tumors ❑ Yes ❑ No	Frequent Headaches ❑ Yes ❑ No
Swollen Ankles ❑ Yes ❑ No	Blood Transfusion ❑ Yes ❑ No	Migraines ❑ Yes ❑ No
Stroke ❑ Yes ❑ No	Hemophilia ❑ Yes ❑ No	Alcohol/Drug Abuse ❑ Yes ❑ No
Artificial Joint(hip,knee,etc) ❑ Yes ❑ No	Bruise Easily ❑ Yes ❑ No	Nervous/Anxiety ❑ Yes ❑ No
Kidney Disease ❑ Yes ❑ No	Anemia ❑ Yes ❑ No	Neurological Disorder ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Ulcers ❑ Yes ❑ No	Psychiatric/Psychological ❑ Yes ❑ No

Do you have or have you had any disease, condition, or problem not listed? ❑ Yes ❑ No

If yes, for what? _____

Women

Are you: Pregnant? ❑ Yes ❑ No #of Months _____ Nursing?: ❑ Yes ❑ No Taking birth control pills?: ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature **Date**

Dentist Signature **Date**

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Are there changes in your health since last visit? ❑ Yes ❑ No

If yes, please explain _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

Are there changes in your health since last visit? ❑ Yes ❑ No

If yes, please explain _____

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

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AUTHORIZATION OF PROTECTED HEALTH INFORMATION

You may refuse to sign this acknowledgment

I. _____, hereby ❑ Authorize ❑ Withdraw permission to
NAME OF PATIENT

OSO Marguerite Dental to disclose the following health information

- Treatment information
- Financial information
- Insurance information
- Medical Health information
- [illegible]

To ❑ Parent _____ ❑ Spouse _____ ❑ Other _____

This authorization will remain in effect until further notice by name listed above or patient/legal guardian if patient is a minor

I understand that by signing this authorization:

- I have the right to withdraw permission for the release of my information. This revocation must be made in writing and will affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatm [illegible] ɔility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient/Guardian Signature	**Date**

Witness Signature	**Date**

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NOTICE OF PRIVATE PRACTICES

The Dental office of OSO Marguerite Dental

Notice of Private Practices, effective April 14, 2003

This notice describes how your medical information may be used, disclosed and how you may gain access to this information. Please review it carefully.

General Information: OSO Marguerite Dental and his staff are committed to maintaining the confidentiality of your Protected Health Information (PHI). A new Federal law requires us to provide patients with a summary of our privacy practices and related legal duties, and your rights in connections with the use and disclosure of your PHI.

What is protected: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires OSO Marguerite Dental to have a special policy for safeguarding PHI received or created in the course of providing dental services to you through this office. Your prescriptions, lab tests and information you proved on the patients health history forms are examples of PHI.

Uses and Disclosures of PHI

- We use you PHI to provide you with safe dental treatment in light of your overall health. We may need to provide information to a Pharmacist or Dental Laboratory to facilitate treatment.
- We may need to discuss your treatment with other Physicians and/or Dentists, with the possibility of referrals to various specialists depending on the conditions being treated.
- We may disclose your PHI to obtain payment for services (i.e.: from insurance providers).
- PHI may be disclosed in connections with healthcare operations, such as accreditation, certification licensing, or reviewing the competence or qualification of Healthcare Providers, as well as for fraud and abuse detection and prevention purposes.
- PHI may be shared with a family member, friends or another person involved in your health care if you do not object to sharing the PHI in the event if an emergency.
- PHI may be needed to identify a workers compensations claim, as provided within the Federal, State and Local Laws.
- We may need to allow a Coroner, or Medical Examiner to identify you, or determine your cause of death using PHI. In addition, PHI may need to be shared by Military Command Authorities if you are or were a member of Armed Forces.
- We may use or disclose your health information (i.e.: recall/ maintenance reminder), in a discreet fashion, to provide you with appointment reminders, such as voice mail messages, postcards, or letters.

Your Rights as a Patient

- The Patient has the right to access his health information, including copies of x-rays, within the statues of California State Law.
- The patients has a right to restrict the way PHI is provided to other staff, family members or other persons from whom the patients would like certain information to be kept confidential.
- The patient has the right to receive an accounting of discloser of PHI. IF this accounting is requested more than once in a 12 month period, a reasonable fee can be charged for such requests.
- The patient has a right to amend his/her PHI.
- The patient has a right to file a complaint to OSO Marguerite Dental, his staff or with the United States Department of Health and Human Services. We take our Complaints Seriously.

Acknowledgment: When first delivering this notice to you. OSO Marguerite Dental will ask that you please sign acknowledgment that you were provided a copy of this **NOTICE.**

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I. _____ have received a copy of this office's:
SELF OR PATIENT NAME IF A MINOR

Notice of Privacy Practices

Please print name self or parent/legal guardian if patient is a minor	
Signature - Self or parent if patient is a minor	**Date**

FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other _____

ACKNOWLEDGEMENT OF MATERIALS FACT SHEET

I have received a copy of the Dental Materials Fact Sheet as required by Law.

Signature - Self or parent if patient is a minor	**Date**

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Our Commitment to You

We would like to take this opportunity to thank you for being an important member of our dental practice and to assure you of our continued commitment to excellence in providing dental care for you and your family. Our office puts one belief above all others; treat every patient as an extension of our own family. In order to maintain the caliber of care and personal service all of you have come to expect from our office, we must adhere to certain standards of care. Please take a few moments to review our office guidelines below.

Appointments

We pre-plan and prepare for your visit. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, your treatment is delayed, often resulting in negative consequences. Likewise, other patients in need of treatment are unable to be seen.

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone, email, and/or text prior to their appointment but please do not depend on this courtesy.

- Should any scheduling changes be required, we **require at least 48 hours advance notice** to avoid a $100.00 cancellation fee.
- In order to cancel/reschedule your appointment, you must call our office - text message is not an acceptable method and will result in a cancellation fee.

By initialing this section, you indicate that you understand and agree to these appointment guidelines. ***X***

Insurance

We are pleased that you have dental insurance to assist you with your dental care. As a courtesy, we are happy to submit your insurance claim to help you receive the full benefits of your dental insurance coverage. Please keep in mind, dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

By initialing this section, you indicate that you understand and agree to these insurance guidelines. ***X***

Financial Arrangements

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, credit cards (VISA, MC, American Express and Discover). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion copays at the time treatment is provided

By initialing this section, you indicate that you understand and agree to these financial guidelines. ***X***

Patient Signature	**Date**

Guardian Signature	**Date**

We appreciate your understanding in our efforts to provide you with a positive experience.