About You

Today's Date: _____

Name:_____

Preferred Name:_____

Birthday:_____**Age:**_____

Social Security #:_____

Home Address:_____

_____

Spouse's Name:_____

Spouse's Birthday:_____

Child's Name:_____

Child's Birthday:_____

Child's Name:_____

Child's Birthday:_____

Employer:_____

Occupation:_____

Hobbies/Interest:_____

Other family members seen by us:_____

Person Responsible for account:_____

Relation:_____

Whom may we thank for referring you?_____

Contact

We like to make reminder calls to you, please make sure we have a home, work and/or cell phone number.

Home #:_____

Cell #:_____

Work: # :_____

Email Address:_____

Please circle one of the follow as your preferred method of contact: Home# Cell# Work#

Emergency Contact:

Name:_____

Relationship:_____

Phone Number #:_____

Address:_____

Insurance Benefits

Dental Coverage? □Yes □No

Insured Name:_____

Insured Birthdate:_____

Insured ID/SS#:_____

Insurance Company Name:_____

Insurance Phone Number:_____

Primary Subscriber's Name(if patient above is not the main subscriber): _____

Group #:_____

Subscriber/ Member ID #:_____

If you have a secondary insurance, please let us know.

"Be generous of your time with your patients."

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment, or any dental treatment performed without prior financial arrangements will be paid for at the time of treatment is performed. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all dental treatment. A service charge of 21% per annum will be charged on the unpaid balance of all accounts over 90 days. I grant my permission to your office to telephone me at home or my work to discuss matters related to this form of my dental treatment. I realize that appointment times are reserved and that if I fail to give at least 48 hours' notice, I may be charged a fee. If my account should be sent to a collection agency, I will be responsible for my insurance be billed by this office, I authorize the Dentist(s) and/or the staff to furnish information to the insurance carrier necessary to complete and/or settle my dental claim. To the best of my knowledge, the above statements on this form are true and complete.

PLEASE INQUIRE ABOUT ANY QUESTIONS WHICH ARE NOT UNDERSTOOD I CONSENT OF TREATMENT

I do authorize and give consent to administer treatment, including but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I further state that the medical and dental history was completed, fully and accurately to the best of my knowledge.

_____ _____

PATIENTS OR REPOSIBLE PARTY'S SIGNATURE **DATE**

Medical History

Name:_____ Birthday:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your body. Health problems that you may have or medication(s) that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	If yes, please explain:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken Phen-Fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances, herbal supplements or medication?			
Do you have a medical condition that requires you to pre-medicate with antibiotics before dental treatments?			

Preferred Pharmacy (Name & Location EX: CVS Rancho Bernardo) _____

Medication Name	Medication Type (Please select one of the following)	Dose / How many I take in each day	Why am I taking this Medication	Date Prescribed
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			
	Tablet **Liquid** **Oral Suspension** **Other:_____** **_____**			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Do you have, or have you ever had any of the following? Please check all that apply.

☐	AIDS/ HIV Positive	☐	Chest Pains	☐	Frequent Headaches	☐	Irregular Heartbeat	☐	Scarlet Fever
☐	Alzheimer's Disease	☐	Cold Sores/ Fever Blister	☐	Herpes	☐	Kidney Problems	☐	Shingles
☐	Anaphylaxis	☐	Congenital Heart Disorder	☐	Glaucoma	☐	Leukemia	☐	Sickle Cell Disease
☐	Anemia	☐	Convulsions	☐	Hay Fever	☐	Liver Disease	☐	Sinus Trouble
☐	Angina	☐	Cortisone Medicine	☐	Heart Attack/ Failure	☐	Low Blood Pressure	☐	Spinal Bifida
☐	Arthritis/Gout	☐	Diabetes	☐	Heart Murmur	☐	Lung Disease	☐	Stomach/ Intestinal Disease
☐	Artificial Heart Valve	☐	Drug Addiction	☐	Heart Pace Maker	☐	Mitral Valve Prolapse	☐	Stroke
☐	Artificial Joint	☐	Easily Winded	☐	Heart Trouble/Disease	☐	Pain in Jaw Joints	☐	Swelling of Limbs
☐	Asthma	☐	Emphysema	☐	Hemophilia	☐	Parathyroid Disease	☐	Thyroid Disease
☐	Blood Disease	☐	Epilepsy or Seizures	☐	Hepatitis A	☐	Psychiatric Care	☐	Tonsillitis
☐	Blood Transfusion	☐	Excessive Bleeding	☐	Hepatitis B or C	☐	Radiation Treatment	☐	Tuberculosis
☐	Breathing Problem	☐	Excessive Thirst	☐	Herpes	☐	Recent Weight Loss	☐	Tumors or Growths
☐	Bruise Easily	☐	Fainting Spells/Dizziness	☐	High Blood Pressure	☐	Renal Dialysis	☐	Ulcers
☐	Cancer	☐	Frequent Cough	☐	Hives or Rash	☐	Rheumatic Fever	☐	Venereal Disease
☐	Chemotherapy	☐	Frequent Diarrhea	☐	Hypoglycemia	☐	Rheumatism	☐	Yellow Jaundice

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain: _____

_____

Women: Are you…

☐Pregnant/Trying to get pregnant?

☐Nursing?

☐Taking oral contraceptives?

☐Is there any chance you may be pregnant?

Are you allergic to the following?

☐Aspirin

☐Penicillin

☐Codeine

☐Acrylic

☐Metal

☐Latex

☐Local Anesthetics

☐Other If yes, please explain:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Dental Information

Name of Previous Dentist:_____

Phone:_____City/ State:_____

How long has it been since your last dental visit?_____ What kind of treatment was done?_____

Does dental treatment make you nervous? YES NO

Are you in pain at this time? YES NO If yes, Where?_____

Do you have any discomforts caused by hot or cold liquids, or sweets?_____

Have you ever had periodontal treatment? YES NO If yes, when?_____

Is there a tendency for dental problems in your family? YES NO If yes, please explain?_____

Does you jaw feel tired or ache? YES NO Do you clench or grind your teeth? YES NO

Do you bite your fingernails, pencils, bobby pins, thread, etc.?_____

Are you happy with the appearance of your teeth?_____

Why do you seek dental care at this time?_____

Have you ever had problems with:

Local Anesthetics? YES NO If yes, please explain?_____

Previous dental treatment? YES NO If yes, please explain?_____

Nitrous Oxide (laughing gas)? YES NO If yes, please explain?_____

What can we do to make your visits more comfortable?_____

Any additional comments?_____

Is there anything about your health history that you have not told us about?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in the medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN_____ DATE:_____

Patient HIPPA consent form

I understand that have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing the consent I authorize you to use and disclose my protected information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in

  my treatment)

- Obtaining payment from third party payer (e.g. my insurance company)

- The day-to-day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time, However, any use or disclosure that occurred prior to the day I revoked this consent is not affected.

Print Patient Name:_____ Date:_____

Signature:_____ Relationship to Patient:_____

NOTICE OF PRIVACY PRACTICES

(Dental)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services b one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this of this would be sending a bill to your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions to the Privacy Officer.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures for protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with the respect to protected health information.
This notice is effective as of January 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA, or to file to file a complaint, please contact:

The U.S Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W, Washington, D,C. 20201
(202)619-0257 or Toll Free: 1-877-696-6775

Insurance and Patient Responsibility

Dear Patient,

This office is a Premier provider for Delta Dental, Cigna and Principal.

Dr. Spalenka, as a courtesy to his patients, will file your insurance claims for you. Please understand that your insurance is an agreement between you and your insurance carrier. Dr. Spalenka has no say in how an insurance claim is paid. This office will do it's best to give you an **ESTIMATE** on insurance payments.

It is your responsibility to know what type of coverage you have and any limitations there may be. There are many different policies and coverage amounts. We will do our best to find out what type of coverage you have, but please understand that any time we call an insurance company to verify insurance, we are told that anything they tell us is "not a guarantee of coverage." They also say, "May or may not apply to your policy."

Due to the length of time most insurance companies now take to pay claims, a lot of dental offices are requiring payment in full from the patient on the day of service. The insurance company then reimburses the patient. We are not currently at that point yet, but patient co-pay amounts are due at the time of service. We will give you an **ESTIMATE** of what we believe your co-payment will be for the service provided. If you require financial assistance, we have assistance through Care Credit. Dr. Spalenka will not do any type of financing through his office. Any balances that are not paid within 30 days after your insurance pays their portion, will be assessed with a monthly finance fee.

I have read, understand and agree to the above statement.

Signature:_____ Date:_____

What are intraoral images?
An intraoral image is defined as a photographic image/images obtained by intraoral or extra oral cameras; these full mouth diagnostic photos are deemed necessary to document diagnosis.

Why do we take them?
lntra oral images are important diagnostic aids for our dentists and professional staff. By taking these images our professionals are able to map out a clear plan and assessment of the patients' needs as well as being able to clearly envision how to correct a problem. lt magnifies the image, enables us to detect lesions, assists the dentists in restoring the tooth's anatomy and, it depicts the severity of the tooth conditions.

These images are also beneficial when it comes to instance filing. At times, x-rays do not support our clinical observations. The images allow us to show insurance companies what we see. Diagnostic photographs provide accurate documentation of the tooth's preoperative condition. Documentation is needed to monitor treatment progress for possible questions by a third-party oater, your insurance.

How we bill?
Our office typically will take anywhere from 1-15 images using code D0471. Our fee for this code is $55.00 (depending on your insurance, price may vary according to the contracted amounts.) Some insurances pay for this code, others do not. Therefore, prices may vary; however, the max out of pocket fee is $55.00.

Photos

I authorize the dentist and his team to take photographs, intraoral slides of my teeth. I understand that the photographs will be used as a record of my care. I understand the max fees of these photos are $55.00 and it is my responsibility, regardless of any promotional values.

Patient Name:_____

Signature:_____ **Date:**_____

I would like to thank you and welcome you to our office.

I'll start by sharing with you what our guiding beliefs are for our patients.

Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires.

With that in mind we would ask you to identify how you would like to be seen in our office by checking which of the 3 levels seem appropriate for you at this time. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this helps as a starting point.

PLEASE SELECT ONE OF THE FOLLOWING:

☐ Level 1: Reactive care, patients at this level are generally only interested in solving more urgent problems and not in a comprehensive exam or long term planning. In addition they typically want the treatment performed to be as inexpensive and efficiently as possible.

☐ Level 2: Proactive care, patients who choose this level of care generally want a thorough examination and want to be involved in the prevention of present and future dental problems. Typically however they choose repair solutions that are not long term in nature.

☐ Level 3: Regenerative care, patients at this level have a high value for their dental health and appearance. They desire a complete dental examination and have a desire to be informed of all findings and the potential consequences of each problem. Ultimately they want to be involved in creating a long term master plan for their dental health which includes choosing the longest lasting solutions to their problems.

We hope these different levels make sense to you, and as we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

Whitening for Life

Dr. James Spalenka DDS is proud to offer our patients Whitening for Life! We pride ourselves on the smiles that leave our practice. We also pride ourselves on knowing our patients are maintaining the best possible oral health. Professional Whitening for Life was developed for those patients that are already taking their dental health seriously, and as an incentive for those who need a little help keeping up with their dental care. The patient will receive custom made, professional, take home whitening trays and gel for personal use.

As with any program, there is always fine print, but the details are simple. Below is a list of the details for the Whitening for Life program. At your next appointment, a qualified staff member will explain in detail and have you read and sign the necessary forms to participate.

Dental Office Responsibilities:

1. Dr. Spalenka's staff will make whitening trays for any of our current patients that are 18 years and older that are medically and dentally able to receive teeth whitening following a regular cleaning and exam. For new patients, Whitening for Life is free with a paid exams and x-rays. (Free whitening offer cannot be combined with any other coupons or specials.)
2. The patient will be scheduled for custom impressions of their teeth, after which the whitening trays will be ready for pick-up within 2 week.
3. Our helpful staff will deliver the custom made trays along with 2 syringes of whitening gel. Patients will be given instructions on the proper usage and answer any patient questions or concerns.
4. Regardless of your cancelation history in our office prior to July 2014, we will allow all patients to participate in this great program, unless health conditions do not allow it. A clean slate is always nice to everyone.

Patient Responsibilities:

1. You must be a current patient on our active files, and should have a cleaning and exam prior to the impression appointment.
2. Patients must keep their regular scheduled cleaning exams and x-ray appointments.
3. If a change comes in your schedule, we require a 48 hours' notice so other patients can be served during your previously scheduled appointment. We will require that you schedule within 4 weeks of the preciously scheduled appointment date.
4. One whitening gel syringe will be rewarded at each cleaning appointment. Additional syringes can be purchased for $15.00.
5. Lost or destroyed trays will be replaced at a cost of $50.00 (per tray) to the patient.
6. Should any of the rules fail to be met, you will be disqualified from the program but will be provided to re-enroll for a $50.00 reactivation fee. In office whitening available for additional fee.

If you have any questions or are interested in becoming a Whitening for Life patient,
we will be happy to assist you at your next visit!

Signature:_____ **Date:**_____