228 Lombard St. Suite B, Thousand Oaks, CA 91360 • Tel: 805 497-3726 • Fax: 805 497-2338 • www.toaksdental.com

WELCOME

HOURS

Our office is pleased to offer you appointments between the hours of 8 and 5:30. Please visit our website www.toaksdental.com for directions and additional interesting information.

APPOINTMENTS

Your first visit is a very important one. We will use this time to get acquainted with you and begin to gather vital information. You can expect to have a complete exam including an examination of your teeth, a complete periodontal exam, cancer screening, necessary x-rays, and a cleaning. The information we gather will be used to custom design a treatment plan for you that fits your needs and desires. If you would like us to review x-rays from a previous office it is your responsibility to bring them to this first visit otherwise a new x-ray survey will be performed at this visit.

Your subsequent visits will be by appointment only. While we make every effort to remain on schedule, occasionally there are unexpected dental emergencies that can cause unexpected delays. We respect the time you have committed to us and will do our best to keep your waiting time to a minimum.

As a courtesy we can call to confirm your appointment, send an e-mail reminder or text to your phone as per your preference. Broken appointments or last minute cancellations are a loss to three people: the patient that missed the valuable time, the patient that could have used the valuable time, and the dentist that was fully staffed and prepared for your visit. If something comes up and you are unable to keep your appointment, we request that you call our office at least 48 hours in advance to reschedule your appointment. We do understand certain circumstances, but a repeated pattern of broken appointments may result in a broken appointment charge.

OFFICE PHILOSOPHY

It is our commitment to maintain the highest standards of our profession and to give our patients the best possible care and help keep their long term costs down through routine visits. We will do so in a warm and friendly atmosphere and be sensitive to the needs of our patients and will always treat them with the respect they deserve.

YOUR TREATMENT PLAN

Once we have gathered all the information for you we will customize a plan and then arrange time to review our findings with you. We will help you to understand what is needed, review alternatives, and possible consequences if treatment is not completed. Financial commitment will be discussed and arrangements made to proceed at a pace with which you are comfortable.

EMERGENCY CARE

If you require emergency treatment, please call as early in the day as possible. If you have-an emergency when the office is closed your call will be forwarded to one of our doctors at (805) 497-3726. Incidentally, you will be glad to know, our patients of record have very few discomfort problems.

THANK YOU

We appreciate and respect the trust you have placed in us. You may rest assured that we will do everything in our power to make your visits as pleasant as possible. The greatest compliment you can give us is to recommend us to your family and friends. We look forward to a long and productive dental relationship with you and a lifetime of beautiful smiles. We welcome new patients.

PATIENT INFORMATION

DATE:_____

NAME:_____ PREFER TO BE CALLED _____
LAST FIRST M

ADDRESS: _____
STREET APT. # CITY STATE ZIP

BIRTH DATE: _____ TELEPHONE: ☐_____ ☐ _____
MO DAY YR HOME OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL):_____ OCCUPATION_____ GRADE_____

ADDRESS: _____ **Cell Ph. No:**_____**E-Mail Address**_____

DENTAL INSURANCE CO.: _____ GROUP NO. _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

FORMER DENTIST: _____
STREET CITY PHONE

PHYSICIAN _____PHARMACY_____PHONE_____

PHYSICIAN'S ADDRESS _____ PHONE _____

FAMILY INFORMATION

	FATHER (OR HUSBAND)	MOTHER (OR WIFE)
Name:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Telephone #:	HOME # WORK #	HOME # WORK #
Birthdate/SS #:	MO DAY YR SS#	MO DAY YR SS#
Employer:	EMPLOYER OCCUPATION	EMPLOYER OCCUPATION
	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Dental Insurance Co.: Group #:	DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY / HOUSEHOLD IN CASE OF EMERGENCY

NAME: _____TEL #_____
LAST FIRST M

ADDRESS: _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

☐ Cash on day of treatment

☐ Visa/Mastercard No. _____ ☐ DenCharge _____

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 the 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 financial arrangements must be paid for in cash at 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 cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 11/2 % 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 listed for this dental case can only be extended for a period of six months from the date of the patient's 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 if 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 condition hereunder shall not constitute a waiver of any further term or 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 fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: _____ Date: _____

SIGNATURE OF RESPONSIBLE PARTY

SS # _____ _____
(STATE DRIVERS LICENSE NUMBER)

X_____DATE:_____

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental conditions, but they are all associated with proper oral health care.
Please answer each question. Circle **Yes** or **No** where applicable.

1. Date of last physical examination _____

2. Are you now under the care of a physician? ..... YES NO
   If so, what is the condition being treated? _____

3. Have you ever had any serious illness or operation? ..... YES NO
   If so, what illness or operation? _____

4. Have you ever been hospitalized? ..... YES NO
   If so, what was the problem? _____

5. Are you taking any medication(s) including non-prescription medicine? ..... YES NO
   If so, what? (Include Dosage) _____

6. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... YES NO

7. Are you sensitive of allergic to any drugs? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin ☐ Codeine;
   ☐ Other If other, what drugs? _____

8. Do you have or have you had any of the following: (please check √ known conditions) YES NO

YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
☐☐ Anemia	☐☐ Bruise Easily	☐☐ Thyroid Disease	☐☐ Pain in Jaw Joints	☐☐ Radiation Treatment of any kind
☐☐ Herpes	☐☐ Head Injuries	☐☐ Mitral Valve Prolapse	☐☐ Respiratory Disease	☐☐ Hepatitis or Jaundice
☐☐ Stroke	☐☐ Heart Failure	☐☐ Cerebral Palsy	☐☐ Sickle Cell Disease	☐☐ Venereal Disease (Syphilis, Gonorrhea)
☐☐ Ulcers	☐☐ Liver Disease	☐☐ Blood Transfusion	☐☐ Tuberculosis (T.B.)	☐☐ AIDS, HIV
☐☐ Diabetes	☐☐ Scarlet Fever	☐☐ Joint Replacement	☐☐ Epilepsy or Seizures	☐☐ TMJ (Temporomandibular joint)
☐☐ Glaucoma	☐☐ Chicken Pox	☐☐ Nervous Disorders	☐☐ Artificial Prosthesis	☐☐ Alzheimers Disease
☐☐ Arthritis	☐☐ Latex Allergy	☐☐ Tumors or Growths	☐☐ Psychiatric Treatment	☐☐ Fen-Phen or Redux
☐☐ Emphysema	☐☐ Sinus Trouble	☐☐ Allergies or Hives	☐☐ Congenital Heart Lesions	☐☐ Osteoporosis Medications
☐☐ Hay Fever	☐☐ Blood Disease	☐☐ Cortisone Medicine	☐☐ Difficulty in Swallowing	☐☐ Other _____
☐☐ Tonsilitis	☐☐ Drug Addiction	☐☐ Excessive Bleeding	☐☐ Heart Ailments or Attack	_____
☐☐ Cold Sores	☐☐ Kidney Disease	☐☐ Asthma	☐☐ Swelling of Feet/Ankles/Hands	
☐☐ Hemophilia	☐☐ Angina Pectoris	☐☐ High Blood Pressure	☐☐ X-Ray or Cobalt Treatment	
☐☐ Rheumatism	☐☐ Mental Disorder	☐☐ AIDS Related Complex	☐☐ Fainting Spells or Seizures	
☐☐ Heart Murmur	☐☐ Rheumatic Fever	☐☐ Chest Pain	☐☐ Chemotherapy (Cancer, Leukemia)	

9. Do you have a persistent cough lasting more than 3 weeks? ..... YES NO
10. Do you have night sweats? ..... YES NO
11. Do you have bloody specs in your phlegm? ..... YES NO
12. Do you have any lingering fever? ..... YES NO
13. Have you had a recent weight loss? ..... YES NO
14. Do you have problems with heartburn? ..... YES NO
15. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... YES NO
16. Do you have any disease, condition or problem not listed? ..... YES NO
    If so, what? _____
17. Do you smoke? If yes, how much _____ per day ..... YES NO
18. (Women) Are you pregnant? If so how many months ..... YES NO
    Are you nursing? ..... YES NO
19. (Women) Do you take birth control pills? ..... YES NO

DENTAL HISTORY

1. Do you think you have active decay or gum problems? ..... YES NO
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... YES NO
3. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO

   If so, explain _____

4. Do you have a dental implant? ..... YES NO
5. How long since your last full mouth X-Rays? ..... _____
6. How long since your last dental treatment? ..... _____
7. Does dental treatment make you nervous? ..... YES NO

   If Yes , Check√: ☐ Slightly ☐ Moderately ☐ Extremely

8. Would you desire to be pre-sedated? ..... YES NO
9. Do you wish to speak to the Dr. privately about any matter? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, Inform the doctor at my next appointment.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs.

All services are rendered and accepted under the terms and conditions

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.

Relationship to the patient: _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____
_____	_____	NONE ☐	_____	_____ DR.	_____

Reviewed by: Doctor _____ Date _____ B.P. _____

NEW PATIENT INTERVIEW

Do you have or wish to discuss any of these problems:

Pain or discomfort associated with your mouth? Snoring? _ YES _ NO

Tooth clenching or grinding? _ YES _ NO

Tender face or neck muscles? _ YES _ NO

Migraines or headaches? _ YES _ NO

Jaw joint pain? _ YES _ NO

Clicking or popping in jaw joint? _ YES _ NO

Bleeding gums? _ YES _ NO

Bad breath? _ YES _ NO

Bad taste in your mouth? _ YES _ NO

Do you have sensitivity to any of the following:

Hot _ YES _ NO

Cold _ YES _ NO

Sweets _ YES _ NO

Biting Pressure _ YES _ NO

Do you need help with any medication to make visits more comfortable? (eg. anti-anxiety medication)

_____

_____

Are there any dental issues not previously mentioned that you wish to discuss?

_____

_____

Please RANK the items below in the order in which they would KEEP YOU FROM having dental treatment. (1) being your biggest concern to (4) being your smallest concern.

___ FEAR of pain ___ COST of treatment ___ MISSING work ___ LACK of Concern

COSMETIC INTERVIEW

Name: _____ Date: ___/_____/____

Do you like the appearance of your teeth?	Yes	No
Are your teeth as straight as you would like them to be?	Yes	No
Do you think you have a "gummy" smile?	Yes	No
Are you happy with the length, width, and shape of your teeth?	Yes	No
Do you have any chipped teeth?	Yes	No
Do you have any missing teeth?	Yes	No
Do you have any spaces between your teeth?	Yes	No
Do you have any discolorations, stains, or spots on your teeth?	Yes	No
Would you like for your teeth to be whiter?	Yes	No
Do you have any dental work that you do not like?	Yes	No
Do you have any silver fillings that you would like to change to white?	Yes	No
Has anyone you've known had any cosmetic dentistry done that interests you?	Yes	No

If there were anything else you could change about the appearance of your teeth, what would it be?

_____

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ **E-mail:** _____

Patient Number: _____

Social Security Number: ____ - ___ - _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to car,y out. treatment. payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of o\.!l' Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Karin Sterling
Telephone: (805) 497-3726 **Fax: (805) 491-2338**
E-mail: admin@toaksdental.com
Address: 228 Lombard Street Ste "B", Thousand Oaks, CA 91360

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation. and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____have had full opportunity to read and consider the contents of this Consent form and your 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 heath care 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 Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke *my* Consent for your use and disclosure of *my* protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: ____/_____/_____

The following persons may be allowed to discuss my treatment, healthcare options and payment arrangements privelege.

Person: _____
Relationship: _____ Date: ____/____/____

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This Form Is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14. 2002).

APPOINTMENT CANCELLATION POLICY

PLEASE NOTE THAT WE MUST CHARGE WHEN THERE IS A LATE CANCELLATION (WITHIN 48 HOURS) OR A "NO SHOW" APPOINTMENT.

We understand that our patients lead busy lives and sometimes are not able to keep appointments. However, we reserve our doctor's and hygienist's time when we make your appointment. A broken appointment is a loss to 3 people; The patient that missed valuable time, the patient that could have used the valuable time, and the dentist that was fully staffed and prepared for your visit.

Therefore, we charge $105.00 - $400.00 depending upon the procedure scheduled. This fee cannot be charged to your insurance company.

We ask for your cooperation in calling at least 48 hours ahead of time if you need to cancel or reschedule your appointment.

When your schedule does not allow you to call with 48 hours notice we will try to fill the appointment and if we are successful we will not charge for the missed appointment. If we are unable to fill it then our missed appointment policy will apply.

Patient: _____ **Date:** ___/___/___

Parent or Guardian: _____ **Date:** ___/___/___

Relationship: _____

FINANCIAL POLICY

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive care. Please understand that prompt payment for services provided is expected. Below, you will find our financial policy. Please read it and sign it before being seen by the doctor.

1. **Full payment is due at the time of service.**
2. **We accept cash, checks, Visa, MasterCard, American Express and Discover.**
3. **If you have dental insurance, you are expected to pay your estimated portion, all co-pays, and deductibles at the time of service.**
4. **We offer extended payments with outside financing with prior arrangements before treatment is started.**

Our office is committed to providing the best treatment for our patients. We will diagnose what is needed to restore and prevent further loss or damage to your teeth and gums. We charge fees that are usual and customary for our area. Our diagnosis will be based on what is in the best interest of your dental health, not what insurance "covers" or what maximum your insurance provides for you. We will however, help you maximize the benefits available to you.

We accept assignment of your insurance benefits. You will be expected to pay your estimated portion of the fee for treatment. Please understand that your portion is only an estimate. The actual amount could vary depending on what your insurance determines when the claim is processed or on unexpected changes of treatment. You are ultimately responsible for any balances of services rendered. Your policy is a contract between you or your employer and the insurance company.

If financial arrangements are made for treatment, we expect you to adhere to those arrangements strictly. We reserve the right to charge 1 ½ % (18% annually) interest charges to any account balance that is more than 60 days overdue. To avoid these charges we ask that you comply with your original financial arrangements. If your account becomes more than 90 days delinquent or you are in need of additional treatment, full payment must be made prior to the time of service.

Patient: _____ Date: ___/___/___

Signature of Patient or Guardian: _____

PATIENTS REQUESTING DENTAL INFORMATION VIA E-MAIL

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in a communication. Our first email to you will verify the email address you provide.

Name: _____

___ I consent and accept the risk in receiving information via email.
I understand I can withdraw my consent at any time.

My email address is: _____

___ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.

My email address is: _____

___ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.