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.:	DENTAL INSURANCE	DENTAL INSURANCE
Group #:	GROUP #	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

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. _____

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

APPOINTMENT AND CANCELLATION POLICY FOR NON-SURGIAL PROCEDURES

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. The Doctor and Hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce the policy of charging for no-show appointments and those appointments not cancelled within 24hours.
There will be a charge of $100 per hour of appointment if we do not receive a call to cancel an appointment within 24 hours.

By signing below, you understand the policy and agree to the terms.

_____ _____

Signature Date

_____

Printed Name

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TREATMENT CONSENT

I hereby authorize and request Vikas Luthra, DDS/ Nomi Luthra DDS to provide dental services for me and or my dependent(s). I give my consent to any advisable and necessary dental procedures, diagnostic aids, medications, or anesthetics to be administered by the attending dentist or by the supervised staff to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me. I have the right to discontinue treatment at any time. If the patient is a minor, I authorize the doctor and supervised staff to perform necessary services and treatment, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I understand that antibiotics and analgesics and other medications can cause allergic reactions and I have informed the doctor of any known allergies that I may have. 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. I acknowledge that no guarantee has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child.

FINANCIAL AND CANCELLATION POLICY

I understand and acknowledge that payment to Vikas Luthra DDS, /Thousand Oaks Dental is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges and that I am responsible for ALL fees regardless of insurance coverage. I understand that as treatment progresses fees may have to be adjusted, but that I will be informed of these adjustments. In the event that my payments are not received by the agreed upon dates, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees. I acknowledge that a billing service charge of 1.5% per month may be added to my account. I understand that a specific amount of time has been reserved especially for me, and if I must change my appointment, there will be a charge. We understand that unplanned issues can come up and you may need to cancel an appointment, but we do require notice as hereby stated. There will be a charge of $100 for a non-surgical appointment if we do not receive a call to cancel an appointment with more than one business day notice. There will be a charge of $200 for a surgical appointment if we do not receive a call to cancel an appointment with more than three business day notice.

INSURANCE

Your dental benefits are based upon a contract made between you or your employer and an insurance company. We will bill your insurance as a *courtesy.* If insurance does not pay within 90 days, we have the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Thousand Oaks Dental cannot render services on the assumption that all charges, even any charges, will be paid by an insurance company. To ensure proper billing Thousand Oaks Dental must have all current insurance information and be notified of any changes. Thousand Oaks Dental will work with you, but we also need your help since this is your insurance policy. Thank you for your understanding.

Print Patient Name _____

Signature _____

Date _____

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\.ll' 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: Nallely Dominguez
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: _____