Welcome to Spectrum Dental Group

Please fill out the following information and sign at the bottom of the back page

Patient Information

Last name_____ First name_____ MI____ Preferred name_____

Sex: □ Male □ Female Birth date: ____/____/_____ Status: □ Married □ Single □ Child □ Other_____

Social Security #: _____-_____-_____ Insurance Card ID #: _____ Driver's License #: _____

Address:_____ City _____ State _____ Zip _____

Home Phone:(_____)-_____ Work Phone:(_____)-_____ Ext._____

Fax #:(_____)-_____ Cell Phone:(_____)-_____ Other:(_____)-_____

E-mail Address: _____Employer: _____

Emergency Contact Person:_____ Phone:(_____)-_____

If the patient is a child, please inform us the name of the School_____ Grade_____

How did you hear about our office? □ Insurance Listing □ Friend □ Family □ Co-Worker □ Doctor □ Walk by

□ SDG Flyers, Coupons, Website □ Google □ Facebook □ City Search □ Yelp □ Yellowpages □ Other_____

Who may we thank for referring you to our office? Name_____

Parent/Guardian or Responsible Party (If different from above)

Last name_____ First name_____ MI____ Preferred name_____

Sex: □ Male □ Female Birth date: ____/____/_____ Status: □ Married □ Single □ Other_____

Social Security #: _____-_____-_____ Insurance Card ID #: _____ Driver's License #: _____

Address:_____ City _____ State _____ Zip _____

Home Phone:(_____)-_____ Work Phone:(_____)-_____ Ext._____

Fax #:(_____)-_____ Cell Phone:(_____)-_____ Other:(_____)-_____

E-mail Address: _____Employer: _____

Do you have the legal custody for the person named above? □ Yes □ No Relationship to the person above: _____

NOTICE OF PRIVACY PRACTICES: I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence. I have also had the opportunity to read the office Notice of Privacy Practices before I decide whether to sign this Consent. The Notice provides a description of the treatment, payment activities, and healthcare operations, of the uses and disclosures the office may make of my protected health information, and of other important matters about my protected health information. If there is any change in my health or medication from this date on I will inform my dental health care provider at my next appointment. Also the treatment rooms are for patients only, parents or non-involved party are not allowed in the treatment rooms unless requested by the dental staff.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient and also the dental staff to perform any necessary services whose name appears on this Health History form, to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous 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 complication of procedures, anesthetics and or drugs. Also, I understand that each dental health care provider is an individual practitioner and is individually responsible for the dental care rendered to me.

CONTINUE ON THE BACK PAGE

DENTAL SERVICE AGREEMENT

DENTAL SERVICES: Are payable at the time of visit. As a form of payment, the office accepts cash, checks, master card, Visa and Amex. For all sedation services we request a minimal deposit to reserve the appointment time for the patient, the deposit will be applied to the total balance of the treatment. The office fees and treatment recommendations will be honored for 90 days. Beyond 90 days, fees will be adjusted to reflect any cost increases and treatment recommendations may need to be updated. If a check for payment is dishonored, or returned for any reason, the office will electronically debit the checking account for the full-face amount of the check, plus the processing fee of $25.00 (or legal limit), plus any applicable sales tax.

INSURANCE BILLING: Patients who wish for the office on their behalf to bill their insurance company need to provide the necessary information in order to bill the insurance promptly. All insurance coverage is only an estimation of benefits and is not a guarantee of payment. Patient is responsible for all Co-pays and/or deductibles not met, as well as remaining balances. If the insurance has not paid within (45) days after the treatment visit, the office requires the patient to make payment in full.

MISSED APPOINTMENTS: The office reserve the right to charge fifty dollars $50.00 per hour for a missed appointment in dental hygiene and one hundred dollars $100.00 per hour for a missed appointment for treatment(s) with doctor. The patient needs to provide the office a minimum of 24 hours notice of cancellation in order to reschedule the appointment. Otherwise the patient will forfeit all deposits made prior without contest.

FINANCIAL ARRANGEMENTS : If the patient's account is turned over to a collection agency or the hands of an attorney for collections, there will be additional attorney fees and collection costs incorporated. It is the patient's responsibility to contact the office if for any reason not able to keep the arranged agreement.

DENTAL SERVICES FINANCING: The only installment payment option is the office works with a dental financing company, who can if upon approved able to finance the dental services. The office has no related interests with the bank except the bank make payments directly to the office for the dental services on behalf of the patient. All financial obligation arrangement made is only between the bank and the patient.

PATIENT RECORD: Unless otherwise provided by law, the charge for record duplication is $25.00 per patient record per occurrence; or $20.00 for X-Rays per patient record per occurrence. The records will be ready within 15 days of the date of the request.

I understand that, by signing below, I am giving my consent to this office to use and disclosure of my protected health information to carry out treatment(s), payment activities and health care operations. I also agree to the terms and have had full opportunity to read and consider with the contents of this consent form, the dental service agreement, the office Notice of Privacy Practices. Should any dispute arise over dental services provided to the patient, that is, whether any dental service rendered as allegedly unnecessary, unauthorized or was improperly, negligently, or incorrectly performed, said dispute will be submitted to an independent arbitrator. The decision of the arbitration shall be binding on both parties. I also acknowledge that I have received a copy of the Dental Board of California Dental Material Fact Sheet dated May 2004. I have read, understood, and agreed to the above. I agree that a photocopy of this authorization shall be as valid and effective as the original forever. I am of legal age and legally competent to make this assignment

Patient / Parent / Guardian Signature	Parent/ Guardian - Print name	Date