RODEO DENTAL & ORTHODONTICS

New Patient Form

Please complete this form and bring it to your appointment.

Fields marked with * are required.

Are you filling this form out for yourself or your child? *

☐ Myself ☐ Child

What is your name?

Only if "Are you filling this form out for yoursel..." is Child

First name *

Only if "Are you filling this form out for yoursel..." is Child

Last name *

Only if "Are you filling this form out for yoursel..." is Child

What is your relationship to the patient? *

Patient Information

First Name *

Preferred Name (if different)

Last Name *

Date of Birth *

MM / DD / YYYY

Gender *

☐ Male ☐ Female ☐ Decline

Social Security Number

Marital Status *

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

How did you hear about us? *

Only if "patient age" is 10

Are you interested in braces or clear aligners? *

☐ Yes ☐ No

Address *

Street address

Apt / Unit

City

State

ZIP

Home Phone

( ) -

Mobile Phone *

( ) -

Patient Photo

Please bring this with you — it cannot be attached to a paper form.

Email *

Do you have an emergency contact? *

☐ Yes ☐ No

Only if "Do you have an emergency contact?" is Yes
Emergency Contact Name *

Only if "Do you have an emergency contact?" is Yes
Emergency Contact Number *
( ) -

Medical History

Do any of the following conditions apply to you? We need this information to keep you healthy and safe. *
List below
☐ None

Are you taking any medications? *
List below
☐ None

Do you have any allergies? *
☐ Yes ☐ No

Only if "Do you have any allergies?" is Yes
Allergies
List below
☐ None

Only if "patient age" is 14; Only if "gender" is Female
Are you pregnant or think you might be pregnant?
☐ Yes ☐ No

Only if "patient age" is 14; Only if "gender" is Female
Are you currently breastfeeding?
☐ Yes ☐ No

Only if "patient age" is 14
Do you use any recreational drugs?
☐ Yes ☐ No

Only if "patient age" is 14
Do you smoke?
☐ Yes ☐ No

Only if "Do you smoke?" is Yes
Approximately how much per day do you smoke?

Do you have a primary care physician?
☐ Yes ☐ No

Only if "patient age" is 14
Are there any developmental disorders? (mental or physical) *
☐ Yes ☐ No

Only if "patient age" is 8
Were there any complications during birth (e.g. preterm birth) or problems with physical growth? *
☐ Yes ☐ No

Only if "Do you have a primary care physician?" is Yes
Physician's Name *

Only if "Do you have a primary care physician?" is Yes
Physician's Number *
( ) -

What is your preferred pharmacy? *

Comments or additional information regarding your medical history

I certify that the information provided is accurate to the best of my knowledge.

Patient or Guardian Signature

Date

Dental History

Why are you changing your dentist? *

- ☐ Change of residence
- ☐ Change of insurance
- ☐ Your office is closer
- ☐ My last dentist retired or closed
- ☐ I am unhappy
- ☐ It was too expensive
- ☐ You were recommended
- ☐ I do not have a previous dentist
- ☐ Other

Only if "Why are you changing your dentist?" is Other
Can you provide more detail? *

What is the reason for your appointment? *

- ☐ Exam
- ☐ Cleaning
- ☐ Pain
- ☐ Cosmetic
- ☐ Second Opinion or Consult
- ☐ Other

Only if "What is the reason for your appointment?" is Other
Can you provide more detail? *

Do you have any additional information you would like to provide relating to your appointment?

Only if "patient age" is 17
Does the patient play any sports? *

- ☐ Yes
- ☐ No

Only if "patient age" is 8
Was there ever a sucking habit (pacifier, finger, thumb) after one year of age? *

- ☐ Yes
- ☐ No

Only if "patient age" is 17
Is there a family history of cavities? *

- ☐ Yes
- ☐ No

Only if "patient age" is 14
Is there frequent snacking between meals? *

- ☐ Yes
- ☐ No

Have you ever had a bad experience at the dentist? *

- ☐ Yes
- ☐ No

Only if "Have you ever had a bad experience at the..." is Yes

Can you provide more detail?

How long has it been since you last saw a dentist?

- ☐ One month
- ☐ Three months
- ☐ Six months
- ☐ One year
- ☐ Two years
- ☐ Three or more years
- ☐ I haven ever been to the dentist

Have you ever had a bad reaction to dental anesthetic? *

- ☐ Yes
- ☐ No

Only if "patient age" is 2

Have you had any complications following dental work? *

- ☐ Yes
- ☐ No

Only if "patient age" is 2

Are your teeth sensitive to hot or cold? *

- ☐ Yes
- ☐ No

Do your gum's bleed when you brush or floss?

- ☐ Yes
- ☐ No

Are you aware of any sores or irritated areas in your mouth? *

- ☐ Yes
- ☐ No

Only if "patient age" is 18

Do you grind your teeth? *

- ☐ Yes
- ☐ No
- ☐ I do not know

Only if "patient age" is 18

Have you ever been diagnosed with periodontal disease? *

- ☐ Yes
- ☐ No
- ☐ I do not know

Only if "Have you ever been diagnosed with periodo..." is Yes

Have you ever received treatment for your periodontal disease? *

- ☐ Yes
- ☐ No
- ☐ I do not know

How often do you brush?

- ☐ Never
- ☐ Occasionally
- ☐ Once a day
- ☐ Twice a day
- ☐ Every time I eat

How often do you floss?

- ☐ Never
- ☐ Occasionally
- ☐ Once a day
- ☐ Twice a day
- ☐ Every time I eat

Only if "patient age" is 18; Only if "Are you filling this form out for yoursel..." is Myself

Do you like your smile?

- ☐ Yes
- ☐ No

Only if "Do you like your smile?" is No

What would you like to change?

- ☐ The position or alignment of my teeth
- ☐ The color of my teeth
- ☐ Gaps in my teeth
- ☐ The shape of my teeth
- ☐ Gummy smile
- ☐ Other

Only if "What would you like to change?" is Other
Can you provide more detail?

Are you interested in knowing more about any of the following?

- ☐ Teeth whitening
- ☐ Replacing missing teeth
- ☐ Straightening teeth
- ☐ White fillings
- ☐ Home care
- ☐ Gummy smile correction
- ☐ Breath control
- ☐ Other

Only if "Are you interested in knowing more about ..." is Other
Can you provide more detail?

Does the dentist make you anxious or nervous?

- ☐ Yes, extremely
- ☐ Yes, moderately
- ☐ Yes, somewhat
- ☐ No

We want your experience to be exceptional. Is there anything you would like us to know?

Do you have dental insurance? *

- ☐ Yes
- ☐ No

Only if "Do you have dental insurance?" is Yes
Can you provide a photo of your dental insurance card?
Please bring this with you — it cannot be attached to a paper form.

Only if "Do you have dental insurance?" is Yes
On this dental insurance, is the patient the subscriber? *

- ☐ Yes
- ☐ No

Only if "On this dental insurance, is the patient ..." is No
Subscriber's Name *

Only if "On this dental insurance, is the patient ..." is No
Subscriber's Social Security Number *

Only if "On this dental insurance, is the patient ..." is No
Subscriber's Date of Birth *

MM / DD / YYYY

Only if "Do you have dental insurance?" is Yes
Name of Insurance Company *

Only if "Do you have dental insurance?" is Yes
Subscriber ID *

Only if "Do you have dental insurance?" is Yes
Subscriber's Employer

Only if "Do you have dental insurance?" is Yes
Insurance Group Number

Only if "Do you have dental insurance?" is Yes
Is there a second dental insurance policy? *

- ☐ Yes
- ☐ No

Only if "Is there a second dental insurance policy?" is Yes
Can you provide a photo of the insurance card?
Please bring this with you — it cannot be attached to a paper form.

Only if "Is there a second dental insurance policy?" is Yes; Only if "Do you have dental insurance?" is Yes

On the second insurance, is the patient the subscriber? *

☐ Yes ☐ No

Only if "On the second insurance, is the patient t..." is No; Only if "Do you have dental insurance?" is Yes; Only if "Is there a second dental insurance policy?" is Yes

Second Insurance Subscriber's Name *

Only if "On the second insurance, is the patient t..." is No; Only if "Do you have dental insurance?" is Yes; Only if "Is there a second dental insurance policy?" is Yes

Second Insurance Subscriber's Social Security Number *

Only if "On the second insurance, is the patient t..." is No; Only if "Do you have dental insurance?" is Yes; Only if "Is there a second dental insurance policy?" is Yes

Second Insurance Subscriber's Date of Birth *

MM / DD / YYYY

Only if "Is there a second dental insurance policy?" is Yes; Only if "Do you have dental insurance?" is Yes

Second Insurance Name *

Only if "Is there a second dental insurance policy?" is Yes; Only if "Do you have dental insurance?" is Yes

Subscriber ID *

Only if "Is there a second dental insurance policy?" is Yes; Only if "Do you have dental insurance?" is Yes

Subscriber's Employer

Only if "Is there a second dental insurance policy?" is Yes; Only if "Do you have dental insurance?" is Yes

Subscriber Group Number

Only if "Do you have dental insurance?" is Yes

I understand that I am financially responsible for any charges not covered by my benefits. It is my responsibility to notify the office of any changes to my benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received. I authorize this office to submit insurance claims on my behalf and to release information necessary to my insurance company for the processing of those claims. I assign all dental benefits for services rendered and authorize and direct my insurance carrier(s) to issue payment directly to you. I certify that the information I have provided is accurate to the best of my knowledge.

Patient or Guardian Signature

Date

Office Policy

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 48 hours advanced notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Payment

Payment in full for your treatment is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, and assigned insurance benefits. In the event there is a shortage due to insurance underpayment, it is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding for more than 30 days after you have been notified of a balance due. Payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

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#policyData-frmb-1776745510552-fld-109 ul,

#policyData-frmb-1776745510552-fld-109 li,

#policyData-frmb-1776745510552-fld-109 p {

background-color: #ededed !important;

}

Patient or Guardian Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services. 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 include a periodic assessment of our documentation protocols, etc. In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health- related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health informationto a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary:

(a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your protected health information for workers' compensation and similar programs.

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 relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures 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 request to receive confidential communications of protected health information from us by alternative means or at alternative locations.The right to access, inspect and copy your protected health information.The right to request an amendment to your protected health information.The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.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 to provide you with notice of our legal duties and privacy practices.

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 provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

877-696-6775 (tollfree)

Patient or Guardian Signature

Date

General Informed Consent

Examinations and x-rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Drugs, medication, and sedation

I understand that antibiotic, analgesics, and other medications can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Changes in treatment

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on teeth, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make these changes as necessary.

Temporomandibular joint dysfunctions

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, that I will be referred to a specialist for treatment,

the cost of which is my responsibility.

With any dental treatment, there is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues. The resulting numbness that could potentially occur is usually temporary, but in rare instances it could be permanent. I understand that every reasonable effort will be made to ensure that any condition is treated appropriately. No guarantee or assurance has been given to me by anyone that any proposed treatment or surgery will cure or improve any conditions.

Dental Materials

A dental materials fact sheet is available at https://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf. A printed copy is also available at the front desk.

Patient or Guardian Signature

Date

PHOTO/MEDIA AUTHORIZATION

As a routine part of our practice, we take photographs and other images of patients and their teeth to diagnose, provide treatment and also for educational and promotional purposes. The Patient signing below (“you”) hereby authorize Rodeo Dental and its assigns (together, the “Practice”) to: (a) take photographs, audio and/or video of you (individually and together, the “Images”); (b) publish the fact that the Practice provided dental services to you and any information or testimonials you provide regarding the Practice, treatment plan, diagnoses, city and state of residence, location of treating facility (collectively referred to herein as the “Information”); (c) reproduce, edit, use, and publish the Images and/or Information (together, “Work Product”) with or without the Patient’s name or attribution, in all forms and media, including but not limited to Internet sites and social media; and (d) obtain copyright registration for any publication that incorporates the Work Product. As consideration, you receive a license to use the Work Product and agree that no additional consideration or compensation will be provided for the Practice’s use of the Work Product and hereby waives all claims to compensation and damages based on the Practice’s use of such Work Product. The term of this Release is for 10 years from the date of the Patient’s signature below (the “Term”) and then perpetually renewing for 10 year terms unless it is earlier terminated. The Patient may terminate the Term, except to the extent that the Work Product has already been used or published by sending a written termination notice to the Practice. The Patient understands that any termination of the Term will not affect any action the Practice took in reliance on this authorization before receipt of the notice.

Patient or Guardian Signature

Date