Alex Rader
ADVANCED DENTISTRY
1855 San Miguel Drive, Suite 12
Walnut Creek, CA 94596
(925) 932-1855
alexraderdds.com

PATIENT INFORMATION

TODAY'S DATE _____

NAME _____ PREFERRED NAME _____

BIRTHDATE _____ AGE _____ SEX ☐ Male ☐ Female

SSN/ID NO. _____ DRIVER'S LICENSE NO. _____

ADDRESS _____ APT/UNIT NO. _____

CITY _____ STATE _____ ZIP CODE _____

HOME TEL. NO. _____ MOBILE NO. _____

EMAIL ADDRESS _____

BEST TIME AND METHOD TO REACH YOU _____

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

OCCUPATION _____

PATIENT EMPLOYER/SCHOOL NAME _____

EMPLOYER/SCHOOL ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMPLOYER/SCHOOL TEL. NO. _____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDATE _____

SPOUSE'S TEL. NO. _____ SPOUSE'S SSN/ID NO. _____

SPOUSE'S EMPLOYER _____

OTHER FAMILY MEMBERS SEEN BY US _____

HOW DID YOU HEAR ABOUT US? _____

WHOM CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

PARENT/LEGAL GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

NAME _____ RELATIONSHIP TO PATIENT _____

SSN/ID NO. _____ DRIVER'S LICENSE NO. _____

ADDRESS _____ APT/UNIT NO. _____

CITY _____ STATE _____ ZIP CODE _____

HOME TEL. NO. _____ MOBILE NO. _____

EMAIL ADDRESS _____

EMERGENCY CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

NAME _____ RELATIONSHIP _____

TEL. NO. _____

DENTAL BENEFIT INFORMATION

DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

IF YES, WHO IS THE SUBSCRIBER TO THIS INSURANCE? _____

SUBSCRIBER BIRTHDATE _____ SUBSCRIBER'S EMPLOYER _____

INSURANCE CO. _____ TEL. NO. _____

SUBSCRIBER ID NO. _____ GROUP NO. _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE (SECONDARY INSURANCE)? ☐ YES ☐ NO

IF YES, WHO IS THE SUBSCRIBER TO THIS INSURANCE? _____

SUBSCRIBER BIRTHDATE _____ SUBSCRIBER'S EMPLOYER _____

INSURANCE CO. _____ TEL. NO. _____

SUBSCRIBER ID NO. _____ GROUP NO. _____

DENTAL HISTORY

PREVIOUS DENTIST'S NAME _____ TEL. NO. _____

DATE OF LAST DENTAL VISIT _____ DATE OF LAST DENTAL X-RAYS _____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

REASON FOR TODAY'S VISIT _____

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO DO YOUR GUMS BLEED? ☐ YES ☐ NO

DO YOU NOW HAVE OR HAVE YOU EVER EXPERIENCED PAIN/DISCOMFORT IN YOUR JAW (TMJ)? ☐ YES ☐ NO

DO YOU SMOKE OR USE CHEWING TOBACCO? ☐ YES ☐ NO

IF YES, FOR HOW LONG? _____ HOW OFTEN? _____

CHECK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD THE FOLLOWING:

BAD BREATH	☐ YES ☐ NO	LOOSE TEETH/BROKEN FILLINGS	☐ YES ☐ NO
BLISTERS ON LIPS OR MOUTH	☐ YES ☐ NO	MOUTH BREATHING	☐ YES ☐ NO
BURNING SENSTION ON TONGUE	☐ YES ☐ NO	MOUTH PAIN, BRUSHING	☐ YES ☐ NO
CHEW ON ONE SIDE OF MOUTH	☐ YES ☐ NO	ORTHODONTIC TREATMENT	☐ YES ☐ NO

CLICKING OR POPPING JAW	☐ YES	☐ NO	PAIN AROUND EAR	☐ YES	☐ NO
DRY MOUTH	☐ YES	☐ NO	PERIODONTAL TREATMENT	☐ YES	☐ NO
FINGERNAIL BITING	☐ YES	☐ NO	SENSITIVITY TO COLD	☐ YES	☐ NO
FOOD COLLECTION BETWEEN TEETH	☐ YES	☐ NO	SENSITIVITY TO HEAT	☐ YES	☐ NO
GRINDING TEETH	☐ YES	☐ NO	SENSITIVITY TO SWEETS	☐ YES	☐ NO
GUMS SWOLLEN/TENDER	☐ YES	☐ NO	SENSITIVITY WHEN BITING	☐ YES	☐ NO
LIP OR CHEEK BITING	☐ YES	☐ NO	SORES/GROWTHS IN MOUTH	☐ YES	☐ NO

IN YOUR OPINION, WHAT DO YOU THINK THE PRESENT STATE OF YOUR DENTAL HEALTH IS?

WHAT DO YOU ALREADY KNOW ABOUT OUR OFFICE AND WHAT ARE YOUR EXPECTATIONS?

HOW HEALTHY DO YOU WANT US TO GET YOUR MOUTH?

☐ DON'T REALLY CARE ☐ AVERAGE ☐ THE BEST IT CAN BE

SHOULD YOU NEED TREATMENT, AT WHAT POINT SHOULD WE ADDRESS IT?

☐ WHEN MY TOOTH HURTS/BREAKS ☐ WHEN SOMETHING IS WORSENING ☐ WHEN SOMETHING ISN'T IDEAL

WHAT QUALITY OF DENTISTRY DO YOU WANT US TO RECOMMEND?

☐ JUST PATCH IT ☐ AVERAGE ☐ IDEAL/THE BEST

WE HAVE THE ABILITY TO LOOK AT YOUR MOUTH FROM 3 DIFFERENT PERSPECTIVES. WHAT COMBINATION OF THESE WOULD YOU LIKE US TO USE FOR YOU?

☐ AS A **GENERAL** DENTIST ☐ AS A **COSMETIC** DENTIST ☐ AS A **FUNCTIONAL** DENTIST

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR FACE AND SMILE?

WHAT WOULD IT TAKE FOR YOU TO TRUST US TO BE YOUR DENTIST?

TELL US ABOUT YOUR GOOD DENTAL EXPERIENCE

AND THE BAD ONES

HAS FEAR EVER BEEN AN ISSUE FOR YOU IN THE DENTAL OFFICE? ☐ YES ☐ NO
WHAT CAUSED YOU TO LEAVE YOUR LAST DENTAL OFFICE?

HAS TIME EVER BEEN A FACTOR IN GETTING YOUR DENTAL WORK DONE? ☐ YES ☐ NO
HAS THE COST OF DENTAL TREATMENT BEEN A CONCERN FOR YOU? ☐ YES ☐ NO
WHAT CAN WE DO TO HELP YOU WITH THIS?

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?

MEDICAL HISTORY

PHYSICIAN'S NAME _____ TEL. NO. _____

DATE OF LAST VISIT _____

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN?" THESE INCLUDE COMBINATIONS OF IONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE), AND REDUX (DEXFENFLURAMINE). ☐ YES ☐ NO

CHECK "YES" OR "NO" TO INDICATE IF YOU HAVE HAD THE FOLLOWING:

AIDS/HIV	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO
ARTHRITIS/RHEUMATISM	☐ YES	☐ NO
ARTIFICIAL HEART VALVES	☐ YES	☐ NO
ARTIFICIAL JOINTS	☐ YES	☐ NO
ASTHMA	☐ YES	☐ NO
BACK PROBLEMS	☐ YES	☐ NO
BLEEDING ABNORMALLY, WITH EXTRACTIONS OR SURGERY	☐ YES	☐ NO
BLOOD DISEASE	☐ YES	☐ NO
CANCER	☐ YES	☐ NO
CHEMICAL DEPENDENCY	☐ YES	☐ NO
CHEMOTHERAPY	☐ YES	☐ NO
CIRCULATORY PROBLEMS	☐ YES	☐ NO
CONGENITAL HEART LESIONS	☐ YES	☐ NO
CORTISONE TREATMENTS	☐ YES	☐ NO
COUGH, PERSISTENT OR BLOODY	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO
EMPHYSEMA	☐ YES	☐ NO
EPILEPSY	☐ YES	☐ NO
FAINTING/DIZZINESS	☐ YES	☐ NO
GLAUCOMA	☐ YES	☐ NO
HEADACHES	☐ YES	☐ NO
HEART MURMUR	☐ YES	☐ NO
HEART PROBLEMS	☐ YES	☐ NO
HEPATITIS (TYPE:___)	☐ YES	☐ NO
HERPES	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
JAUNDICE	☐ YES	☐ NO
KIDNEY DISEASE	☐ YES	☐ NO
LIVER DISEASE	☐ YES	☐ NO
LOW BLOOD PRESSURE	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO
NERVOUS PROBLEMS	☐ YES	☐ NO
PACEMAKER	☐ YES	☐ NO
PSYCHIATRIC CARE	☐ YES	☐ NO
RADIATION TREATMENT	☐ YES	☐ NO
RESPIRATORY DISEASE	☐ YES	☐ NO
RHEUMATIC FEVER	☐ YES	☐ NO
SCARLET FEVER	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO
SINUS TROUBLE	☐ YES	☐ NO
SKIN RASH	☐ YES	☐ NO
SPECIAL DIET	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
SWOLLEN ANKLES/FEET	☐ YES	☐ NO
SWOLLEN NECK GLANDS	☐ YES	☐ NO
THYROID PROBLEMS	☐ YES	☐ NO
TONSILLITIS	☐ YES	☐ NO
TUBERCULOSIS	☐ YES	☐ NO
TUMOR/GROWTH ON HEAD OR NECK	☐ YES	☐ NO
ULCER	☐ YES	☐ NO
VENEREAL DISEASE	☐ YES	☐ NO
WEIGHT LOSS, UNEXPLAINED	☐ YES	☐ NO

WOMEN

ARE YOU PREGNANT ☐ YES ☐ NO

IF YES, DUE DATE _____

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

ALLERGIES

☐ ASPIRIN
☐ BARBITURATES (SLEEPING PILLS)
☐ CODEINE
☐ IODINE
☐ LATEX
☐ LOCAL ANESTHETIC
☐ PENICILLIN
☐ SULFA
☐ OTHER (PLEASE LIST)

_____

_____

MEDICATIONS

DRUG NAME AND DOSAGE	FREQUENCY	DIAGNOSIS

PHARMACY NAME _____

TEL. NO. _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have dental insurance coverage and assign directly to Alex Rader DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize Alex Rader DDS to release pertinent information about my medical and dental condition for the purpose of securing health and dental insurance benefits information, authorization, or payment for devices or services. I will provide a current copy of my insurance identification card, policy number, and demographic information to Alex Rader DDS upon request.

I also authorize Alex Rader DDS to act as my representative and on my behalf to secure authorization necessary from my insurance company regarding a procedure or medical/dental order, including, if necessary, any appeal of a denial of benefit and in billing to my insurance carrier.

I understand that I may revoke this authorization at any time by giving Alex Rader DDS a written statement to withhold my personal, medical, and dental information from that time forward.

Patient's Signature (Parent/Legal Guardian if patient is a minor) Date

Printed Name

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty
Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect April 13, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or

qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization
In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services
We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards, letters, email, or text message. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights
Access
You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment
You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact:

Alex Rader DDS
1855 San Miguel Drive, Suite 12
Walnut Creek, CA 94596
(925) 932-1855

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may

send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Alex Rader DDS complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Alex Rader DDS's Notice of Privacy Practices.

Patient's Signature (Parent/Legal Guardian if patient is a minor) Date

Printed Name

AUTHORIZATION TO RELEASE INFORMATION

Other than myself, I authorize Alex Rader DDS and his staff to release information about my medical and dental treatment to the following persons. I also understand that I may revoke this authorization at any time by giving Alex Rader DDS a written statement to withhold my personal, medical, and dental information from that time forward.

Name	Relationship to Patient

Patient's Signature (Parent/Legal Guardian if patient is a minor) Date

Printed Name

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our practice is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy.

PAYMENT
Payment for services is due before services are rendered unless prior written arrangements have been made with our office.

We accept the following forms of payment: cash, check, Visa, MasterCard, and CareCredit.

A 3% discount will be given to patients who decide to pre-pay their estimated co-payment at least 1 business day prior to their scheduled appointment.

For minor patients, the parent/legal guardian that accompanies the minor child/children to the appointment is responsible for any payment due.
Checks that are returned to our office from your financial institution are subject to a $40.00 returned check fee. This fee covers the processing fees that are charged to our office.

INSURANCE

Our office understands the value of insurance benefits to our patients. As a courtesy, will fill out and file your dental insurance forms on your behalf. However, if your insurance company has not paid your claim within 60 days, the balance may be transferred to your account.

It is to your benefit to present your complete insurance information before the time of services. This will allow us to verify with your carrier the amount they will be contributing toward your treatment and allows us to present you with a more accurate estimated co-payment amount. We strive to keep a very healthy patient relationship and not jeopardize that relationship by presenting future un-anticipated financial responsibilities.

All insurance co-pays and deductibles are expected to be paid before services are rendered.

By signing below, you indicate that you understand and agree to honor our Financial Policy as stated above.

Patient's Signature (Parent/Legal Guardian if patient is a minor) Date

Printed Name

MISSED RESERVATION / SHORT NOTICE CANCELLATION POLICY

Our practice strives to provide you with exceptional personalized dental care. We want to be courteous of your time. Therefore, unlike other offices, we strive to always be punctual. We ask for the same kindness in return. If you find that you are unable to keep your reservation, we require 48-hour notice. While we realize that emergencies do arise, giving us notice to reschedule or cancel your reservation will keep us from having tor revoke your appointment privilege.

If you miss a reservation without notifying us at least 48 hours in advance, we reserve the right to charge $75 per hour of time reserved. This fee must be paid before any future reservations can be made.

Please help us serve you better by keeping your reservations.

By signing below, you indicate that you understand and agree to honor our Missed Reservation/Shor Notice Cancellation Policy.

Patient's Signature (Parent/Legal Guardian if patient is a minor) Date

Printed Name

SUBMIT FORMS