RIVERSTONE DENTAL GROUP

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver License: _____

Prefer Phone: _____ Other #: _____ E-mail: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____
Name Number

Physician Name & Number: _____ Medical Record # _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

YES NO	YES NO	YES NO	YES NO
☐ ☐ AIDS	☐ ☐ Glaucoma	☐ ☐ Pregnancy	☐ ☐ Codeine Allergy
☐ ☐ Allergies - Latex	☐ ☐ Growths	Due date: _____	☐ ☐ Penicillin Allergy
☐ ☐ - Bisphosphonate	☐ ☐ Hay Fever	☐ ☐ Radiation Treatment	
☐ ☐ Anemia	☐ ☐ Head Injuries	☐ ☐ Respiratory Problems	OTHER: Allergies to Medications (indicate)
☐ ☐ Arthritis	☐ ☐ Heart Disease	☐ ☐ Rheumatic Fever	☐ _____
☐ ☐ Artificial Joints	☐ ☐ Heart Murmur	☐ ☐ Rheumatism	
☐ ☐ Asthma	☐ ☐ Hepatitis	☐ ☐ Sinus Problems	☐ _____
☐ ☐ Blood Disease	☐ ☐ High Blood Pressure	☐ ☐ Stomach Problems	
☐ ☐ Cancer	☐ ☐ Jaundice	☐ ☐ Stroke	Blood Pressure: _____
☐ ☐ Diabetes	☐ ☐ Kidney Disease	☐ ☐ Tuberculosis	
☐ ☐ Dizziness	☐ ☐ Liver Disease	☐ ☐ Tumors	
☐ ☐ Epilepsy	☐ ☐ Mental Disorders	☐ ☐ Ulcers	
☐ ☐ Excessive Bleeding	☐ ☐ Nervous Disorders	☐ ☐ Venereal Disease	
☐ ☐ Fainting	☐ ☐ Pacemaker		

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you being treated for any medical condition at the moment? ☐ Yes ☐ No
  If yes, please explain: _____
- List all medical surgeries you had in the past: _____
- List all medications you are taking: _____
  _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient/Parent Signature _____ Date: _____

Doctor Signature _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other/Name _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, 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 services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, 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 as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

We are currently using unencrypted email. Do we have your permission to send you e-mails regarding your treatment, financial, or insurance information? YES / NO

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian/responsible party

_____ Date: _____
Doctors Signature

RIVERSTONE DENTAL GROUP

401 Gregory Lane, Suite 242
Pleasant Hill, CA 94523
Bus.: (925) 689-1020 Fax: (925) 689-1028

APPOINTMENT CANCELLATION POLICY

In order to provide the best possible service to you, we ask that you take a moment and read the following information regarding our policy:

We respect and understand your busy schedules. Therefore, we do not double book appointments and your appointment time is reserved just for you. If you must cancel or reschedule an appointment, please notify us at least 48 hours prior to your scheduled appointment time.

Any last minute changes to your appointment, greatly affects our office and prevents another patient from having that appointment time available to them. When a patient does not show up for, cancels, or reschedules his/her appointment with less than 48hrs notice, it affects the dentist's and staff's time and wastes materials used in preparation for the visit. More importantly, your dental care is delayed, which in many cases further complicates the condition and adds to your expense.

If you cannot keep your appointment, you are expected to contact our office during regular work hours with at least 48hrs notice. Appointment cancellations, rescheduled appointments, and missed appointments without 48hrs notice will be accrue a $85 fee. Initial_____

Additionally, patients who repeatedly miss their appointments may be subject to dismissal from future care by this office. Thank you in advance, for your understanding and consideration.

I have read the Cancellation Policy and I understand and agree to abide by this policy:

_____ _____

Signature of Patient or Responsible Party Date

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Financial Policy

Thank you for choosing us as your dental health care provider. We believe all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Before treatment is performed, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard. Care Credit may also be available to you with extended payment plans with prior credit approval.

Insurance:
We request that any co-payments, deductible, and any services not covered by your insurance plans be paid at the time the service is provided. The balance is your responsibility where your insurance company pays or not.

Your insurance policy is a contract between you and your insurance company.
We are not a party to the contract. If your insurance company has not paid your account in full, the balance will be automatically transferred to your account. Please be aware some and possible all of the services provided may be non-covered services and not considered reasonable, usual and customary under the terms of your dental and/or medical policy.

Usual and Customary:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payments Plan:
Gregory Ln. Family Dentist and Implant Dental Practice has partnered with Care Credit, a patient financing company, to offer our patients deferred interest financing (0%) for 6, 12, 18 or 24 months with approval. No other payment plans are available.

Missed Appointments:
Unless cancelled within at least 48hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. ($50.00) Please help us serve your better by keeping your scheduled appointments.

Billing:
Balance which is 60 days old or older will incur a monthly 1.5% finance charge which equal an 18% per annum rate. There is also a $30.00 returned check fee.

Refunds:
Refunds for overpayments will be sent after the all treatment is completed and insurance has been collected.

Collections:
Any accounts that have not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the financial policy. I understand and agree to this financial policy

Patient Name:_____ Patient signature: _____ Date:_____

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HIPAA
Consent for use and Disclosure of Health Information

Name:_____

Patient's Name(s): _____ Insurance ID #: _____

_____

Address: _____ Telephone: _____ Social Security Number: _____

TO THE PATIENT, PARENT, OR GUARDIAN — 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 carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Joint 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 our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. You are entitled to a copy of this form if you would like one... just ask. 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 Joint 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 Joint Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

TREATMENT CONSENT FORM

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1. EXAMINATIONS AND X-RAYS
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. DRUGS, MEDICATIONS, AND SEDATION
I have been informed and understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissue, 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 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 care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. CHANGES IN TREATMENT PLAN
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, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Shahani to make any/all changes and additions as necessary.

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. FILLINGS
I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed filling.

6. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize Dr. Shahani to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. CROWNS, BRIDGES, CAPS, VENEERS, AND BONDING
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. DENTURES-COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

9. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. PERIODONTAL TREATMENT
I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

11. DENTAL MATERIALS FACT SHEET
I have received and read a copy of the dental materials fact sheet as required by law.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I acknowledge the receipt of and understand post-operative
instructions and have been given an appointment date to return.

Patient/Parent Signature:_____ **Date:**_____ **Doc:**_____