PATIENT INFORMATION

DATE _____

NAME _____ ☐MARRIED ☐SINGLE ☐MINOR ☐MALE ☐FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐PATIENT ☐GUARDIAN ☐SPOUSE ☐FATHER ☐MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐Yes ☐No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No

☐Payment in full at each appointment (cash or personal check)

☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)

Card # _____ Exp. Date _____

☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Milk ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	☐	☐	Excessive Bleeding	☐	☐	Chemotherapy	☐	☐	Night Sweats	☐	☐	Cold Sores	☐	☐
Heart Murmur or Defect *	☐	☐	Sickle Cell Disease	☐	☐	Osteoporosis	☐	☐	Yellow Jaundice	☐	☐	Fever Blisters	☐	☐
Irregular Heart Beat	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Bisphosphonates	☐	☐	Kidney Problems	☐	☐	Herpes	☐	☐
Angina/Chest Pain	☐	☐	Leukemia	☐	☐	Osteonecrosis of Jaw	☐	☐	Renal Dialysis	☐	☐	Stroke	☐	☐
Heart Attack/Failure	☐	☐	Recent Blood Transfusion	☐	☐	Aredia I.V.	☐	☐	Thyroid Disease	☐	☐	Convulsions	☐	☐
Congenital Heart Disorder*	☐	☐	Swelling of Limbs	☐	☐	Zometa I.V.	☐	☐	Parathyroid Disease	☐	☐	Epilepsy or Seizures	☐	☐
Mitral Valve Prolapse *	☐	☐	Lung Disease	☐	☐	Fosamax, Actonel, Boniva	☐	☐	Arthritis/Gout	☐	☐	Fainting or Dizziness	☐	☐
Scarlet Fever	☐	☐	Breathing Problem	☐	☐	Stomach/Intestinal Disease	☐	☐	Rheumatism	☐	☐	Glaucoma	☐	☐
Rheumatic Fever *	☐	☐	Shortness of Breath	☐	☐	Ulcers	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Artificial Heart Valve *	☐	☐	Frequent Cough	☐	☐	Recent Weight Loss	☐	☐	Cortisone Medicine	☐	☐	Nervousness	☐	☐
Heart Pace Maker*	☐	☐	Hay Fever	☐	☐	Frequent Diarrhea	☐	☐	Artificial Joint *	☐	☐	Psychiatric Care	☐	☐
Pulmonary Shunt*	☐	☐	Sinus Trouble	☐	☐	Diabetes	☐	☐	Sexually Transmitted Disease	☐	☐	Alzheimer's Disease	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐	Excessive Thirst	☐	☐	AIDS	☐	☐	Allergies (Medicines)	☐	☐
Low Blood Pressure	☐	☐	Bloody Sputum	☐	☐	Hypoglycemia	☐	☐	HIV Positive	☐	☐	Allergies (Pollen / Dust)	☐	☐
Bacterial Endocarditis*	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Genital Herpes	☐	☐	Hives or Rash	☐	☐
Unexplained Fever	☐	☐	Tuberculosis	☐	☐	Hepatitis A (Infectious)	☐	☐	Drug Addiction/Alcoholism	☐	☐	Need Premedication?	☐	☐
Bruise Easily/Blood Disease	☐	☐	Cancer	☐	☐	Hepatitis B or C	☐	☐	Tattoos/Body Piercing	☐	☐	Ever taken fen-phen?*	☐	☐
Anemia	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Protease Inhibitor	☐	☐				Cochlear implants?	☐	☐
Coronary Stent*	☐	☐												

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____
History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	_____	Dr. _____

Acknowledgement
Of
Privacy Practices

Tracy D. Benhamou, D.D.S.
62 Oak Street
Brentwood, CA 94513
(925) 634-9237

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then are bound to abide my such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent Family Members also covered by this acknowledgement:

_____

_____

Dr. Tracy Benhamou
62 Oak Street
Brentwood, Ca 94513
(925) 634-9237

Patient Receipt of Dental Materials Fact Sheet

I acknowledge that I have read a copy of the Dental Materials Fact Sheet dated October 2001.

_____ _____

Patient Signature Date

The Dental Board of California
Dental Materials Fact Sheet
Adopted on 10/17/01

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guided to dental materials science.

The most frequently used , materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin ionomer cement, ceramic porcelain, and porcelain fused to metal, gold alloys (noble) and nickel or cobalt-chrome (base metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors and compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A glossary of terms is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 and 2001. In some cases, where contemporary research is spare, we have indicated our best perceptions based upon information that pre-dates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the Dentists technique when placing the restoration, the ancillary.

Materials used in the procedure, and the patient's co-operation during the procedure. Following restoration of the teeth, the longevity of the work will be strongly influenced by the Patients compliance with dental hygiene and home care, their diet and chewing habits.

FINANCIAL POLICY

Tracy D. Benhamou, D.D.S.
62 Oak Street, Brentwood, CA 94513
Tel. (925) 634-9237 Fax (925) 634-9238

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

Regarding Payment

Payment of **ESTIMATED** patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients.

Therefore, we offer the following payment options:

1.We accept the following forms of payment: Cash, Check, Visa MasterCard and Discover
2.Flexible payment plans of up to 12 months no interest upon approval with Care Credit®. Approval must be received prior to treatment date.

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the financial coordinator. If dentures, partial dentures, crowns and/or bridges, retainers, mouthguards or nightguards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is delivered.

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.

Regarding Insurance

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. Your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of service.

Thank you for understanding our Financial Agreement. I have read the Oak Street Family Dental Financial Agreement. I understand and agree to this Financial Agreement.

Signature of Patient or Responsible Party:_____ Date:_____

Cancellation and Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. We know your time is valuable, and ours is too. Out of respect for our staff and our other clients, we ask that you give us at least 48 hours notice if you need to cancel an appointment. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 48 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call our office between the hours of 8:00 am - 5:00 pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 48 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $50 fee per hour of your reserved time.

Signature (Responsible Party) Date