Patient Information

Last Name: _____ M_____ First Name _____
Preferred Name:_____ Home phone: (_____)_____
Address: _____ City:_____
State: _____ Zip: _____ Gender: M ○ F ○ Unknown ○
Marital Status: Single ○ Married ○ Child ○ Widowed ○ Divorced ○
Driver's License No._____ State:_____
Birth date:_____ Soc. Security #:_____
Email: _____
Wireless Phone: (_____)_____ **Would you like to receive Text Messaging :**
. ○ ○ ○ ○ ○ **YES** ○ **NO**

Occupation: _____ Employer:_____
Bus. Address: _____ City:_____
State: _____ Zip: _____ Work phone: (_____)_____
Preferred Contact Method: Do not call ○ Home ○ Work ○ Cell ○ Email ○ Text Message ○

Referred by:_____
Spouse's Name: _____ _____ _____
Why did you come to our office?_____
Person to contact in case of emergency _____
Relationship_____ Phone (_____)_____
Name of person financially responsible for patient _____
Billing address _____
_____

Dental Insurance Information

Insured's name _____
Birth date:_____ Soc. Security #:_____
Address_____
Relationship to Subscriber: Self ○ Spouse ○ Child ○ Life Partner ○ Other_____
Insurance Co. _____ Phone (_____)_____
Insurance Co. Address: _____ City:_____
State: _____ Zip: _____ Group No. _____
Do you have dual coverage? Yes ○ No ○ If yes: Please complete the following secondary insurance information
Insured's name _____Insured's Soc. Sec. # _____
Birth date:_____ Insurance Company _____
Ins Co Address _____
Group No. _____

Patient's Initials_____

RICHARD HABER DDS Inc
Medical/Dental History

1) Do you presently have or have you had pain or discomfort in the mouth, face, or jaws? ☐ YES ☐ NO
2) Do your gums bleed at any time? ☐ YES ☐ NO
3) Do you have aching or sensitive teeth? ☐ YES ☐ NO
4) Have you had food collection between your teeth? ☐ YES ☐ NO
5) Have you had serious trouble associated with any previous dental treatment? ☐ YES ☐ NO
6) Did you have gum/periodontal treatment before? ☐ YES ☐ NO
7) Date of your last dental treatment : _____

8) My main reason for coming in today is: _____

9) Have you been a patient in a hospital during the past two years? ☐ YES ☐ NO
   If yes, for what reason? _____
10) Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO
   If yes, for what reason? _____

   Please provide the name, address, and telephone number of your physician: _____

   _____

11) Did you whiten your teeth before ? ☐ YES ☐ NO
12) Are you interested in having a cosmetic evaluation ☐ YES ☐ NO
   If yes, please specify what you would like to improve : _____
13) Are you interested in whiter teeth? ☐ YES ☐ NO
14) Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? **If so, please list here:**

DRUG	DOSE/FREQUENCY	REASON FOR TAKING

15) Do you have any allergies (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications? ☐ YES ☐ NO

   If yes, allergic to what? _____
16) Have you ever had excessive bleeding requiring special treatment? ☐ YES ☐ NO
17) When you walk upstairs or take a walk, do you ever have to stop because of chest pain? ☐ YES ☐ NO
18) Do your ankles swell during the day? ☐ YES ☐ NO
19) Do you use more than two pillows to sleep? ☐ YES ☐ NO
20) Have you lost or gained more than 10 pounds in the last year? ☐ YES ☐ NO
21) Do you wake up short of breath? ☐ YES ☐ NO
22) Are you on a special diet? ☐ YES ☐ NO
23) Women: Are you pregnant now? ☐ YES ☐ NO
   Are you currently using a prescription-type contraceptive? ☐ YES ☐ NO
24) Check any of the following which you have had or have at present:

Yes ☐ No ☐ Heart Failure
Yes ☐ No ☐ Heart Disease or Attack
Yes ☐ No ☐ Angina Pectoris (chest pain)
Yes ☐ No ☐ Tuberculosis (TB)
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Congenital Heart Lesions
Yes ☐ No ☐ Scarlet Fever
Yes ☐ No ☐ Artificial Heart Valve

Yes ☐ No ☐ Kidney Disease
Yes ☐ No ☐ Stomach Problems
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Tumor
Yes ☐ No ☐ Shortness of Breath
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ Yellow Jaundice

Yes ☐ No ☐ Rheumatism
Yes ☐ No ☐ Cortisone Medication
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Pain in Jaw Joints
Yes ☐ No ☐ AIDS or HIV antibody
Yes ☐ No ☐ Blood Transfusion
Yes ☐ No ☐ Drug Addiction
Yes ☐ No ☐ Bruise Easily
Yes ☐ No ☐ Sexually Transmitted Disease

(CONTINUED ON NEXT PAGE)

Patient's Name: _____

RESET FORM

RICHARD HABER DDS Inc
Medical/Dental History

Yes ☐ No ☐ Heart Pacemaker	Yes ☐ No ☐ Hay Fever	Yes ☐ No ☐ Cold Sores or Fever Blisters
Yes ☐ No ☐ High Blood Pressure	Yes ☐ No ☐ Allergies or Hives	Yes ☐ No ☐ Epilepsy or Seizures
Yes ☐ No ☐ Heart Murmur	Yes ☐ No ☐ Diabetes	Yes ☐ No ☐ Fainting or Dizzy Spells
Yes ☐ No ☐ Heart Surgery	Yes ☐ No ☐ Thyroid Disease	Yes ☐ No ☐ Nervousness
Yes ☐ No ☐ Artificial Joint	Yes ☐ No ☐ Radiation Treatment	Yes ☐ No ☐ Psychiatric Treatment
Yes ☐ No ☐ Fast, Irregular Heartbeat	Yes ☐ No ☐ Chemotherapy	Yes ☐ No ☐ Sickle Cell Disease
Yes ☐ No ☐ Stroke	Yes ☐ No ☐ Arthritis	Yes ☐ No ☐ Hemophilia or Anemia
Yes ☐ No ☐ Irritable Bowel	Yes ☐ No ☐ Sinus Trouble	Yes ☐ No ☐ Depression

25) Do you have a history of any genetic, congenital, or family-type disorder? …… ☐YES ☐NO

26) Do you have any disease, condition, or problem not listed? …….. ☐YES ☐NO

If yes, please describe here: _____

27) How do you feel about maintaining a healthy mouth? _____

_____

28) How do you feel about the appearance of your teeth? _____

_____

29) If you could change anything about your smile, what would you change? _____

_____

30) If you have a website , please enter it here: _____

To the best of my knowledge, all of the preceding health history answers are true and correct.

Driver's License No: _____ State: _____

Signature: _____ Date: _____

(PATIENT OR GUARDIAN)

Person to contact in case of an Emergency: _____

Relationship To Patient: _____

Phone: _____

MEDICAL HISTORY UPDATE

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____

Patient's Name: _____

RESET FORM

Richard Haber DDS Inc
1260 15th St #701
Santa Monica CA 90404
Tel: (310) 393-7766

Payment Agreement

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and understanding of our payment policy. We offer the following methods of payment of fees:

A. Payment in full is due at the time of service.

B. For patients with insurance, we will accept payment directly from the insurance company, **but require that the deductible and non-covered fees be paid at each visit**.

C. We partner with Care Credit for a financing option. To apply go to www.carecredit.com. If approved, print off approval with your account number and bring to your appointment.

D. Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered. We do not bill individual parents for child's co-payment.

Important Information Regarding Your Insurance

1 Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.

2 Not **all** dental services are a covered benefit in all contracts.
It is your responsibility to know your benefits. We are an in network provider for Delta Dental Insurance. We are an out of network provider for other dental insurance plans, your copay might be higher.

3. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.

4. If you ask, an **ESTIMATE** will be given to you of the benefits that your insurance may be expected to pay. Remember that this is only an **ESTIMATE** and that the actual cost may vary.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

Patient or Responsible Party – Print Name _____

Signature _____ Date _____

TERMS AND CONDITIONS

The under signed hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. I have answered all questions truthfully and to the best of my knowledge. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2 % per month (18% per annum) (but in no event more than the maximum rate permissible under state law will be charge on the unpaid principle balance on all accounts not paid within 90 days of treatment date. I understand that the fee estimated listed for this dental case can only be extended for the period of six months from the date of the patient's examination. Additionally, I agree that a waiver for any breach of any proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, 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 agree to their content. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

TREATMENT AND ARBITRATION AGREEMENT (three arbitrators are required)

With regard to dental care and services provided or to be provided by Dr. Haber is agreed that Dr. Haber will provide dental care and services to the patient, to the best of his skills and knowledge, which dental care in the light of circumstances is possible and practical. It is agreed that because of differences in human constitution and response, it is in no way possible to warrant the outcome of any medical or dental service. It is understood that any dispute as to dental malpractice, that is as to where any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of the law before jury, and instead are accepting the use of arbitration. Within a reasonable time, two arbitrators shall select a Licensed Dentist as neutral 3rd arbitrator and give notice to the selection thereof to the parties. The three arbitrators shall hold a hearing within a reasonable time. All notices or other papers required to be served by United States mail. The arbitration shall be conducted in accordance with and governed by the provision of Title 9 of the California Code of Civil Procedure.

By signing this agreement, the patient understands that the patient's rights to a jury trial are waived.

All services are rendered and accepted under the terms and conditions printed above:

Signed: _____ Date:_____

Authorization must be signed by the patient, or by the nearest relative in the case of minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

Doctor signature: _____Date: _____

PROTECTING YOUR PRIVACY

CONSENT TO USE
AND/OR
DISCLOSURE OF PATIENT INFORMATION

As a patient of **RICHARD HABER DDS Inc, 1260 15th St #701, Santa Monica Ca 90404, Tel: (310) 393-7766** you have the right to know how we may use and disclose information about you. More information about this is provided in our "Notice of Patient Privacy Practices information" on our website: http://www.drhaber.net/forms.htm and in our office.

Please review our Notice of Patient Privacy Practices before signing this form.

As our Notice of Privacy Practices explains, we need your consent to use or disclose information about you so that we can provide you with health or dental treatment; arrange payment for your care; and conduct certain kinds of administrative health or dental care operations. By signing this Consent below, you agree that we may use or disclose information about you for these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or dental care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number given above if you want more information or to request additional restrictions.

You have the right to revoke this Consent at any time, but must do so in writing.
A revocation of this Consent will not apply to any use or disclosure of information which happened before we received your written revocation. Please contact us at the address and phone number above if you want more information, or to revoke this Consent.

We may change our Notice of Privacy Practices from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you come in for an appointment. You may obtain a copy of our current Notice upon request to our address and phone number given above.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health and dental care operations.

Name of Patient:_____

Signature : _____

Date : _____

DENTAL MANTERIALS FACT SHEET

The Dental Board mailed the DMFS to all licensed dentists in mid-November. A copy is available at the CDA web site, www.cda.org, and http://www.drhaber.net/dental_factsheet_2001.pdf

Beginning January 1, 2002 each dentist must provide a copy of the DMFS to any patient (new or of record) prior to commencing any dental restorative work.

The dentist must obtain a signed acknowledgement that the patient has received the fact sheet, and a copy of the signed acknowledgement must be placed in the patient's record.

I HAVE READ / RECEIVED A COPY OF THE DMFS

Patient Name: _____

Patient Signature: _____

Date: _____