Select Dental- San Leandro
Alireza Mola, DDS
Welcome to our Practice!

PATIENT INFORMATION FORM

Today's date _____

Patient Name: First _____ **MI**_____ **Last**_____ **Nickname**_____

Address: Street _____ **City**_____ **State**_____ **Zip**_____

Phone: Home _____ **Work**_____ **Mobile**_____

Email Address: _____

Social Security Number_____ **Date of Birth** _____

Drivers License # _____ **State** _____

Patient Employed By _____ **Occupation** _____ **Phone**_____

Address: Street _____ **City** _____ **State** _____ **Zip** _____

Sex: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Emergency Contact

Name _____ **Relationship to Patient** _____

Home phone _____ **Mobile Phone** _____

FOR PARENTS OF MINORS

Is the patient a minor? ☐**Yes** ☐**No** **Full-time Student:** ☐**Yes** ☐**No** **Name of school** _____

Primary Residency: ☐ **Both parents** ☐ **Mom** ☐ **Dad** ☐ **Step Parent** ☐ **Shared Custody** ☐ **Guardian**

Name of Responsible Party: First _____ **Last** _____

Date of Birth: _____ **Relationship to Patient:** ☐**Self** ☐**Spouse** ☐ **Parent** **Other**_____

Address: (*if different from patient*) **Street** _____ **City** _____ **State**_____ **Zip**_____

Phone: Home _____ **Mobile** _____ **Work** _____

Employer: (*if different from above*) _____ **Occupation** _____

DENTAL BENEFIT PLAN INFORMATION

Primary Dental Plan Name: _____ **Phone:** _____

Address: Street _____ **City** _____ **State** _____ **Zip** _____

Name of Insured: _____ **Date of Birth** _____ **ID Number** _____

Policy Number: _____ **Patient Relationship to Insured** _____

Secondary Dental Plan Name: _____ **Phone:** _____

Name of Insured: _____ **Date of Birth** _____ **ID Number** _____

Patients Relationship to Insured: _____

Select Dental
145 East 14th Street Suite #100
San Leandro, CA 94577
Office: 510-587-9400 Fax: 510-878-7791

WHOM MAY WE THANK FOR REFFERING YOU? ☺

☐ One of our valued patient? (*name of patient*) _____

☐ Online (please state where) _____

☐ Insurance Company (Name) _____

☐ Other _____

Please list other members of your family who are patients in our practice :

_____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance to performing any treatment with our practice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients understand the coverage of their dental benefit plans.

If we are a contracted provider with your plan, you are responsible for your portion of the approved fee as determined by your plan. We are required to collect the patients portion in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will reflect this.

If we are not a contracted provider with you dental benefit plan, it is the patients responsibility to verify if their plan allows them reimbursement from out-of-network providers. If your plan allows reimbursement, our practice can file a claim with your plan and receive direct reimbursement if you assign benefits to us. In this circumstance you are responsible and will be billed for any unpaid balance. If you choose not to assign benefits to our practice, you are responsible for filing claims and receiving direct reimbursement from your dental plan and will be responsible for payment before or at the time of service.

Unencrypted e-mail is not a safe way of communication. There are some risks that health information takes while being sent via e-mail. If the patient would like to receive treatment information through e-mail, we will use the most minimum amount of health information possible. Our first e-mail will verify the e-mail address.

☐ I consent to the risk in receiving medical information via E-mail.

☐ I do not consent to the risk in receiving medical information via E-mail.

I have read the above and agree to the financial terms. _____(initials)

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I have consented to during diagnostics and treatment. _____(initials)

I authorize the release of information necessary to process my dental benefit claims. I herby authorize payment directly to this doctor otherwise payable to me.

I hereby acknowledge that a copy of this practices Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any question I may have regarding this Notice.

Signature _____ **Date** _____

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Select Dental

Appointment Policy

Please read and sign

- Our office is open from 9:00am-6:00pm Monday-Friday. The last appointment is scheduled at 4:00pm, 4:30PM for hygiene appointments only.We are open 2 Saturdays per month from 7:00am-2:00pm with the last appointment scheduled at 1:00pm, 1:30 for hygiene.

- We understand how important our patients timeis. The Doctors at Select Dental and the staff make it a priority to stay on schedule. Please help us by being on time for your scheduled appointment. If you are **more than 15minutes late** to your scheduled appointment, you may be rescheduled.

- We reserve a specific time for your appointment. If you need to cancel or reschedule your appointment, please notify us as soon as possible. Our office requires a 48 hour notice, from the scheduled time of your appointment to avoid a charge. **A missed appointment or late cancellation for a hygiene appointment Monday-Friday results in a $50.00 per hour charge. A missed appointment or late cancellation for a treatment appointment Monday-Friday results in a $75.00 per hour charge.** Your dental insurance does not cover this charge.

- Our office opens 2 Saturday per month. A missed appointment or late cancellation on a Saturday will result in a charge of **$75.00 per hour whether hygiene or treatment.**

- Our office does our best to try to accommodate your schedule. When possible we may open before office hours or see you past our normal scheduling hours, to accommodate you. When this is arranged, A non-refundable deposit of $50.00 will be needed. If the appointment is for treatment the non-refundable deposit will be needed **PLUS** 50% of your payment for the service being rendered.

I have read, understand, and agree to adhere to the office policy, I confirm acceptance of these policies.

Patient Signature _____ Date: _____

Patient Name (printed) _____

Signature of parent/Guardian of Minor_____

Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Select Dental- San Leandro, CA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the disclosures of my health information. I understand that this organization has the right to change *its Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below 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, payments, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relation to Patient: _____

Patient Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

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CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Type/ Date of surgery: _____		
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexually transmitted disease
Yes / No Pacemaker		
Date implanted: _____		
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No Local anesthetic	Yes / No Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Antidepressants	Yes / No Herbal supplements	

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you tested positive for COVID-19?
If YES, date of positive test result: _____

Yes / No Are you experiencing any ongoing or lasting symptoms or effects as a result?
If YES, what are these symptoms or effects? _____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above?
If YES, please list _____

If patient answers "yes" to any of the questions above, consider seeking additional information from the patient regarding their symptoms and medications, prior to treatment.

Yes / No **Are there any issues or conditions that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____