EAST COUNTY PERIODONTICS

Periodontal Therapy & Dental Implants

W E L C O M E

Patient Information

Date _____

Name _____

Address _____

City _____

State _____ Zip Code _____

SS# or Ins ID# _____

E-mail _____

Sex □M □F Age_____ Birthdate _____

Occupation _____

Whom may we thank for referring you? _____

Phone Numbers

Home (_____) _____

Cell Phone (_____) _____ _____

Best time and phone to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Phone _____

Dental Insurance

Insurance Co. _____

Group # _____

Are you, or the patient, covered by additional insurance? □Yes □No

Subscriber's Name _____

Birth Date _____Group# _____

Relationship to Patient _____

Subscriber's Employer _____

Insurance Co ._____

SS# or Ins. ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to

Name of Insurance Company(ies)

Dr. Edithann J. Graham all have 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.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, parent, Guardian or Personal Representative

_____ _____

Date/ Relationship

Dental History

Reason for today's visit_____

General Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a mark on "yes" or "no" to indicate if you have had the following:

Bad Breath	□Yes □No	Cigarette, pipe, or cigar smoking	□Yes □No	Mouth pain with brushing	□Yes □No
Bleeding Gums	□Yes □No	Clicking or popping jaw	□Yes □No	Orthodontic treatment	□Yes □No
Blisters on lips or mouth	□Yes □No	Dry mouth	□Yes □No	Periodontal treatment	□Yes □No
Burning sensation on lips or mouth	□Yes □No	Fingernail biting	□Yes □No	Sensitivity to cold	□Yes □No
Chew on one side of mouth	□Yes □No	Food collection between the teeth	□Yes □No	Sensitivity to heat	□Yes □No
		Grinding teeth	□Yes □No	Sensitivity to sweets	□Yes □No
		Gums swollen or tender	□Yes □No	Sensitivity when biting	□Yes □No
		Jaw/muscle pain or tiredness	□Yes □No	Shingles	□Yes □No
		Lip or cheek biting	□Yes □No	Sores or growths in your mouth	□Yes □No
		Loose teeth or broken fillings	□Yes □No	How often do you floss? _____	
		Mouth breathing	□Yes □No	How often do you brush? _____	
				Dental tools used _____	

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Health History

Patient Name:_____

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

Place a mark on “yes” or “no” to indicate if you have had any of the following:

AIDS/HIV	□Yes	□No	Headaches	□Yes	□No	Sinus Trouble	□Yes	□No
Anemia	□Yes	□No	Heart Murmur	□Yes	□No	Skin Rash	□Yes	□No
Arthritis/Rheumatism	□Yes	□No	Heart Problems	□Yes	□No	Special Diet	□Yes	□No
Artificial Heart Valves	□Yes	□No	Hepatitis Type ____	□Yes	□No	Stroke	□Yes	□No
Artificial Joints	□Yes	□No	Herpes	□Yes	□No	Swollen Feet or Ankles	□Yes	□No
Asthma	□Yes	□No	High/Low Blood Pressure	□Yes	□No	Swollen Neck Glands	□Yes	□No
Back Problems	□Yes	□No	Jaundice	□Yes	□No	Thyroid Problems	□Yes	□No
Bleeding abnormally, with			Kidney Disease	□Yes	□No	Tonsillitis	□Yes	□No
extractions or surgery	□Yes	□No	Liver Disease	□Yes	□No	Tuberculosis	□Yes	□No
Blood Disease	□Yes	□No	Mitral Valve Prolapse	□Yes	□No	Tumor or growth	□Yes	□No
Cancer	□Yes	□No	Nervous Disorders	□Yes	□No	Ulcer	□Yes	□No
Chemical Dependency	□Yes	□No	Osteoporosis	□Yes	□No	Venereal Disease	□Yes	□No
Chemotherapy	□Yes	□No	- If “Yes”, are you currently, or have you ever taken			Weight Loss, unexplained	□Yes	□No
Circulatory Problems	□Yes	□No	bisphosphonates ex. Actonel, Boniva, Fosomax etc.?			Do you wear contact lenses?	□Yes	□No
Congenital Heart Disease	□Yes	□No	Please list:_____			Women:	□Yes	□No
Cortisone Treatments	□Yes	□No	Pacemaker	□Yes	□No	Are you pregnant?		
Cough, Persistent or bloody	□Yes	□No	Psychiatric Care	□Yes	□No	Due Date _____	□Yes	□No
Diabetes	□Yes	□No	Radiation Treatments	□Yes	□No	Are you nursing?		
Emphysema	□Yes	□No	Respiratory Disease	□Yes	□No	Taking birth control pills?	□Yes	□No
Epilepsy	□Yes	□No	Rheumatic Fever	□Yes	□No	Do you have any other conditions not listed above? If so,		
Fainting or dizziness	□Yes	□No	Scarlet Fever	□Yes	□No	please list: _____		
Glaucoma	□Yes	□No	Shortness of Breath	□Yes	□No			

Medications

List any medications (including aspirin) you are currently taking and the correlating diagnosis:

_____

_____

_____

Physician Name: _____

Date of last visit: _____

Pharmacy Name_____

Phone (_____)_____

Allergies

□ Aspirin

□ Barbiturates (Sleeping pills)

□ Codeine

□ Iodine

□ Latex

□ Local Anesthetic

□ Penicillin

□ Sulfa

□ Other

_____

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OFFICE POLICY AND PATIENT CONSENT

First, our team would like to welcome you to East County Periodontics. As a patient in our practice, we must inform you of our office policies and procedures. If you would like a copy for your records, please ask; we will gladly duplicate any documents you sign so you may have them for future references.

As a courtesy, we can easily bill your insurance plan for the estimated portion the insurance may cover. Any unpaid portion of your treatment balance is your responsibility to pay, regardless of insurance estimation, denial, or level of coverage. Our practice makes every effort to estimate your insurance benefits and apply it to your treatment plan. As an additional courtesy to our patients, pre-authorizations can be submitted to determine what your insurance will agree to pay on your treatment plan.

Services rendered on an emergency basis must be paid in full, and your insurance can be billed for you afterward. If your plan pays for services that were rendered during an emergency visit, you will receive reimbursement for any credit due to you. Any unpaid patient balance that you owe may be subject to interest charges if unpaid after 60 days. Payment can be made by check, cash, debit or credit.

Your privacy and confidence are important to us. At times, we may, in accordance with HIPPA, discuss your treatment or share your information with the insurance company you provide to us to charge for your treatments or other doctors involved in your patient care. You give us permission to share information about you in a reasonable and confidential manner to bill your insurance and coordinate treatment with any other medical/dental provider involved in your patient care. Dr. Graham, DDS and authorized members of the East County Perio staff to take photographs and/or videos of my face, mouth, teeth, and jaws, before and after treatment. I consent to allow the photographs to be used for the following professional purposes: insurance purposes, dental records, dental research, dental education, for myself and others, including but not limited to training purposes, lectures, presentations..

For appointments involving sedation, copayments must be made prior to arriving at your appointment. We know that your time is valuable and as a courtesy, we ask that you respect the doctor's time and efforts as we have many patients to serve. If you need to cancel an appointment we must have no less than 2 business days to notify our office; so we can offer the time to another patient. For Tuesday or Wednesday appointments, any cancellations must occur before 4pm on Thursday. Appointments canceled without notice of 2 business days, may incur a $75.00 charge per each hour block of time for dental cleanings; and $100 per each hour block of time for surgical procedures. Appointments are times reserved especially for you. If a cancellation is necessary, we can offer that time to someone who may need it and easily reschedule your visit for another appointment time that is convenient for you.

I request Edithann J. Graham, DMD, MD, Inc. to bill my dental/medical insurance for those procedures that are anticipated to be covered. I request that Edithann J. Graham, DMD, MD, Inc. not bill my dental/medical insurance for procedures that are not anticipated to be covered.

I HAVE READ THE ABOVE STATEMENT AND AGREE TO ITS TERMS SET FORTH BY DR. EDITHANN J GRAHAM SIGNATURE OF PATIENT

PRINTED NAME: _____ RELATIONSHIP TO PATIENT:_____

PATIENT'S SIGNATURE:_____ DATE:_____

LEGAL GUARDIAN: _____ DATE:_____

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UNDERSTANDING PATIENT INSURANCE YOU ARE RESPONSIBLE FOR THE FOLLOWING:

Knowing the extent and limitation of your dental care benefits. A detailed explanation of your dental benefits is available in your dental plan handbook/contract. If you do not have one, you can obtain one by contacting your dental plan. If you receive your coverage through an employer, you may also contact your plan administrator for an outline of your dental plan benefits and how they work.

Working with your plan benefits for coverage is not an exact science. Much of what we do and rely on is contacting and representative at your dental insurance company; and asking them specific questions about your coverage. This does not promise payment by your dental plan. Coverage can be denied for payment by your plan for any reason. “Fine-print” explanations not available to your office may apply to how your benefits are applied and paid. Contract restrictions by your plan are outlined in your dental coverage handbook.

Any outstanding claims unpaid by your dental plan for other doctors or providers may reduce what we initially determine is available to use of your dental plan. It’s the patient’s responsibility to keep track of how much is used by your dental insurance. Our staff will call to ask what plan benefit maximum remains; but, if the amount varies due to outstanding claims, the information is not readily known until all claims are paid.

Your general dentist has referred you to our practice for treatment. Our practice does not rely on your dental plan benefits to dictate what treatment you need. If your insurance plan determines that their professional review of your case and deem treatment questionable, we rely on the decision of your referring doctor and the doctor(s) at our practice to diagnose what treatment is necessary for your dental care.

We work with our patients, insurance companies, and doctors closely to make the claim process as simple as possible. When there are occurrences where insurance will not cover payment of benefits estimated for your treatment costs, appeals can be made, reports may be required for you or your referring doctor; and our office will make every effort to assist in redeeming your plan benefits.

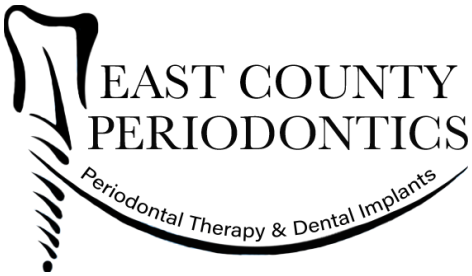
Ultimately, when any balance is left unpaid by your plan for the portion estimated to be covered by insurance, you are responsible to pay it in full within 30 days. Most dental claims are paid within 30 days of your treatment. Unpaid claims that are not appealed are typically settled in 30 days. When a final decision is made regarding any claims in question for coverage or payment, payment of the balance is then due within 30 days of receiving your account statement.

Please be advised, that a request can be made to your dental plan for a pre-determination of plan coverage at any time prior to treatment. This process can delay patient treatment if the decision to wait is of the patient's preference. The request for a pre-determination of plan coverage can sometimes take 30-60 days or more. If it is your decision to wait for a pre-determination before beginning any treatment, you are responsible for contacting your insurance to follow up with this process. Our office will submit a predetermination for you and then wait for an answer from your insurance; which typically will be sent to us by mail.

We appreciate your cooperation in understanding your benefits and help in processing your claims when needed. Please be advised that this information is made available to you, so that you are aware of how some insurance companies work for dental plan benefits and claim processes.

PRINTED NAME: _____ SIGNATURE:_____ DATE:_____

Your signature here acknowledges this notice to patients with dental plan benefits.



Edithann J. Graham, PC
Joshua Weinberger, D.D.S.
266 Avocado Ave Ste A • El Cajon, CA 92020
P: 619.440.2152
E: eastcountyperio@gmail.com
www.eastcountyperio.com

AUTHORIZATION OF THE RELEASE OF DENTAL RECORDS

I hereby authorize East County Periodontics to release the information in the dental records of

_____ (patient's name) to

_____
(name of dentist, physician, clinic or patient's representative)

_____
(address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any except as specifically provided below.

_____

_____

This authorization is effective as of _____ (date)
I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient, please indicate relationship:

- ❏ Parent or guardian of minor patient
- ❏ Guardian or conservator of an incompetent patient
- ❏ Beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws, It is not intended as a "Consent" or Authorization" for the use and disclosure of Protected Health Information (PHI) under federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (this is 8 point)