AESTHETIC DENTISTRY OF NOE VALLEY

4145 24th Street
San Francisco, CA 94114
Tel: (415) 285 7007
www.aestheticsmiles.com

Patient Information

(Please fill out, sign and print)

Contact Information

Mr./Mrs./Ms/Miss/Dr. _____ _____ _____
Last First MI

Preferred Pronouns: □ He/Him □ She/Her □ They/Them □ Other Please list: _____

□ Single □ Married □ Child □Widowed □ Partnered □ Other

_____/_____/_____ _____-_____-_____ _____ _____
Date of Birth Social Security Number Driver's License Number E-mail

May we confirm future appointments by E-mail? □ Yes □ No

_____ _____ _____ _____
Street Address City State Zip

(_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Phone Work Phone Cell Phone

_____ _____
Employer Address

How did you find us/Referred by? _____

Dental Insurance

In most cases, fees will be due in full at the time of services. If you have dental insurance, we will send a claim along with supporting documentation and/or x-rays to your insurance carrier on your behalf, indicating you have paid for fees in full and request that they reimburse you directly for whatever you are entitled to. The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier directly. Dental insurance estimates are exactly that, estimates. Our office does not have access to fee schedules that dental insurances companies base their benefit percentages on.

Dental Insurance Information

Patients relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other

Subscriber's Name_____ _____ _____
Last First MI

_____/_____/_____ _____-_____-_____ (_____) _____-_____
Date of Birth Social Security Number Telephone

_____ (_____) _____-_____
Subscriber's Employer Telephone

_____ _____ _____ _____
Insurance Carrier Group Name Group Number Subscriber/Insurance ID Number

_____ _____ _____ _____ (_____) _____-_____
Insurance's Street Address City State Zip Insurance's Telephone

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Secondary Dental Insurance Information

(Please fill out, sign and print)

Patients relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other

Subscriber's Name_____ _____ _____
Last First MI

_____/_____/_____ _____-_____-_____ (_____) _____-_____
Date of Birth Social Security Number Telephone

_____ (_____) _____-_____
Subscriber's Employer Telephone

_____ _____ _____ _____
Insurance Carrier Group Name Group Number Subscriber/Insurance ID Number

_____ _____ _____ _____ (_____) _____-_____
Insurance's Street Address City State Zip Insurance's Telephone

_____
Signature

_____
Printed Name

_____/_____/_____
Date

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Health History

(Please fill out, sign and print)

We are a health centered dental practice. Thus we are concerned with your total well-being, not just your oral health. An essential part of our approach is a complete health history. Please, fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank you!

_____ _____/_____/_____
Physician's name (MD) Date of last visit

Have you had any serious illnesses or operations? □ Yes □ No If yes, please describe _____

_____

(For Women Only) Are you pregnant? □ Yes □ No If yes, approximate due date _____/_____/_____

Please check if you have had any of the following:

□ Yes □ No – Anemia
□ Yes □ No – Shortness of Breath
□ Yes □ No – Special Diet
□ Yes □ No – Chem. Dependency
□ Yes □ No – Artificial Joints
□ Yes □ No – Skin Pain
□ Yes □ No – Mitral Valve Prolapse
□ Yes □ No – Fainting
□ Yes □ No – Swollen feet or Ankles
□ Yes □ No – Thyroid Problems
□ Yes □ No – Psychiatric Care
□ Yes □ No – Heart Problems
□ Yes □ No – Cortisone Treatments
□ Yes □ No – Chemotherapy
□ Yes □ No – Ulcer
□ Yes □ No – Hepatitis
□ Yes □ No – Liver Disease
□ Yes □ No – AIDS
□ Yes □ No – Cough, Persistent
□ Yes □ No – High Blood Pressure
□ Yes □ No – Arthritis
□ Yes □ No – Artificial Heart Valve
□ Yes □ No – Swollen Neck Glands
□ Yes □ No – Asthma
□ Yes □ No – Stroke
□ Yes □ No – Nervous Problems
□ Yes □ No – Glaucoma
□ Yes □ No – Cancer
□ Yes □ No – Tobacco Habit
□ Yes □ No – Hemophilia
□ Yes □ No – Respiratory Disease
□ Yes □ No – Chest Pain
□ Yes □ No – Circulatory Problems
□ Yes □ No – Scarlet Fever
□ Yes □ No – Venereal Disease
□ Yes □ No – Other autoimmune Dx.
□ Yes □ No – Cough Up Blood
□ Yes □ No – Jaw Pain
□ Yes □ No – Kidney Disease
□ Yes □ No – Diabetes
□ Yes □ No – Heart Murmur
□ Yes □ No – Epilepsy
□ Yes □ No – Back Problems
□ Yes □ No – Blood disease
□ Yes □ No – Pacemaker
□ Yes □ No – Headaches
□ Yes □ No – Radiation Treatment
□ Yes □ No – Tonsillitis
□ Yes □ No – Tuberculosis
□ Yes □ No – Rheumatic Fever
□ Yes □ No – High Cholesterol
□ Yes □ No – Fibromyalgia
□ Yes □ No – HIV

Please explain items checked YES: _____

_____

List any medications you are currently taking: _____

Have you EVER taken or are currently taking bisphosphanates (e.g.Fosamax)? □ Yes □ No

Allergies: □ Aspirin □ Barbiturates □ Codeine □ Local Anesthetics
□ Penicillin □ Sulfa □ Latex (gloves) □ Other: _____

1. I hereby authorize the doctors or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____/_____/_____ _____ _____/_____/_____
Patient's Signature Date Doctor's Signature Date

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Personal Dental History

(Please fill out, sign and print)

Name _____

Preferred Name _____

Previous Dentist's Name _____

When was your last dental cleaning and exam before our office? _____

Purpose of today's visit _____

Have you consulted with any other dentist about this? □ Yes □ No

Do you need to be pre-medicated prior to dental procedures? □ Yes □ No

Do you now have or have you ever had any of the following?

□ Yes □ No – Are you in pain
□ Yes □ No – Are your wisdom teeth out
□ Yes □ No – Have you ever had braces? Invisalign/Traditional
□ Yes □ No – Have you ever seen a Periodontist
□ Yes □ No – Gum disease
□ Yes □ No – Clicking or popping jaw
□ Yes □ No – Pain around ear
□ Yes □ No – Loose or broken teeth or fillings
□ Yes □ No – Botox/Fillers
□ Yes □ No – Grind your teeth
□ Yes □ No – Jaw pain or tiredness (TMJ)
□ Yes □ No – Do you wear a Night guard or Retainer
□ Yes □ No – Lip or cheek biting
□ Yes □ No – Food collection between teeth
□ Yes □ No – Bad Breath
□ Yes □ No – Any previous trauma to the head/neck
□ Yes □ No – Sores, blisters or growths

Sensitivity to:
□ Yes □ No – Cold
□ Yes □ No – Sweets
□ Yes □ No – Heat
□ Yes □ No – Biting/Chewing

Would you like to know what options are available to you to:
□ Yes □ No – Create a more attractive smile
□ Yes □ No – Look younger
□ Yes □ No – Keep your teeth for life

_____ _____/_____/_____
Signature Date

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To Request X-rays and Treatment Records from another Dental Office

(Please fill out, sign and print)

To minimize your exposure to radiation, it is very important to know when you last had x-rays taken AND the type of x-rays. Please provide our office with this information prior to your appointment.

I, _____, hereby request and authorize

_____
(Practice or Dentist Name)

to disclose and provide copies of any and all clinical treatment records and information concerning my care, that is in the possession of this person and entity to:

Aesthetic Dentistry of Noe Valley
4145 24th Street
San Francisco, CA 94114
Phone: (415) 285-7007
Fax: (415) 285-1969
E-mail: info@aestheticsmiles.com

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.
I expressly release from liability the above named person or entity form from any and all liability arising from compliance with this request and disclosure of the requested information.

_____ _____/_____/_____
Patient's or Guardian's Signature Date

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Consent for Dental Procedures

(Please fill out, sign and print)

Before receiving treatment, you should ask the doctor about the procedure(s) recommended, and ask any questions you may have before you decide whether or not to give your verbal consent for the procedure(s) to be done. All dental procedures involve some risk of unsuccessful results and complications, and no guarantee is made as to the result of treatment. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment, including not having the treatment at all. You have the right to consent or to refuse any proposed procedure at any time prior to its performance. To keep you more comfortable during treatment you may receive a local anesthetic or possibly a sedative. In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. There is also a small risk of nerve damage as a result of a local anesthetic injection. Sedatives may temporarily make you drowsy or deduce your coordination. If you do take a sedative during the dental procedure, you will need assistance getting home.

X-rays
Dental x-rays will be taken as necessary and appropriate for examination, diagnosis, consultation, and treatment.

Dental Records
The records, x-rays, photographs, models, and other materials relating to your treatment in the office of Dr. Krishnaiah are the property of the doctor. You have the right to inspect such materials and to request copies. You may request to have copies of your dental x-rays sent to another health care provider by signing a 'Release of Records' form.

Cancellation Policy
If you are unable to keep an appointment, you must notify the office at least 48 hours in advance. An appointment that is missed or canceled with less than 48 hours notice might result in a missed appointment fee. TWO CANCELLATIONS OR NO SHOWS MAY BE CAUSE TO DISCONTINUE FURTHER TREATMENT.

Your signature on this form certifies that you have read and understand the information provided, that you have received a copy, and that you accept the terms and conditions described above.

_____ _____/_____/_____
Signature Date

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Arbitration Agreement

(Please fill out, sign and print)

Article 1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical 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 a 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2. a) Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whenever born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law. b) Treatment covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration. d) Other Doctors (If Applicable). Patient understands that he or she may at times receive treatment from one or more doctors who practice jointly with the undersigned doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such doctors practicing with the undersigned doctor will be subject to compulsory, binding arbitration. d.) Coverage of prenatal claims (if Applicable). Patient understands and agrees that, if Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article 3. a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days. b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 90 days, Patient may initiate arbitration by notifying Doctor to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Doctor shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision. c) Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C. C. P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the Medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State. d) Interpretation of Agreement. Any controversy concerning the interpretation or application of this Agreement itself shall also be submitted to arbitration in the manner provided above.

Article 4. Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from medical services rendered prior to revocation shall be subject to arbitration.

_____

Patient's Name (Please print)

_____ _____/_____/_____

Signature Date

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Notice of Privacy Practice

(Please fill out, sign and print)

This notice describes how health information from you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 03 / 15 / 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time.

Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment and healthcare options. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to other dental or medical providers. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written permission, we cannot disclose your health information for any reason except those disclosed in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member or other person designated by you to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filed prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

_____ _____/_____/_____

Signature Date

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Policy for Missed Appointments

(Please fill out, sign and print)

There is a $110 charge for a missed appointment if not cancelled 48 hours in advance. This will not be covered by your insurance. You may also be dismissed from the office if you fail to show up for your scheduled appointment.

I have read, understood, and agree to the above charge for a missed appointment.

_____
Patient's Name (Please print)

_____ _____/_____/_____
Signature Date