Beach Family & Cosmetic Dentistry
Daryl W. Yokochi, D.D.S. & Toan D. Nguyen, D.D.S.
17732 Beach Blvd., Suite A • Huntington Beach, CA 92647 • (714) 842-0601

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

(Cell): _____ E-mail: _____ Driver's Lic.#: _____

Address: _____
Street Apartment #
City State Zip Code

Name of person or office referring you to our practice: _____

RESPONSIBLE PARTY INFORMATION

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

EMPLOYMENT INFORMATION

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

HEALTH INFORMATION

Do you have / have you had (please check those that apply):

☐ AIDS	☐ Dizziness	☐ Hepatitis	☐ Respiratory Problems	☐ Tumors
☐ Anemia	☐ Epilepsy	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Ulcers
☐ Arthritis	☐ Excessive Bleeding	☐ Kidney Disease	☐ Rheumatism	
☐ Artificial Joints	☐ Fainting	☐ Nervous Disorders	☐ Sinus Problems	
☐ Asthma	☐ Glaucoma	☐ Pacemaker	☐ Sleep Apnea	
☐ Blood Disease	☐ Head Injuries	☐ Current Pregnancy	☐ Stomach Problems	
☐ Cancer	☐ Heart Disease	Due date:_____	☐ Stroke	
☐ Diabetes	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis	

- ☐ Yes ☐ No Do you have any mental disorders?
  If yes, please specify: _____
- ☐ Yes ☐ No Do you have any allergies?
  If yes, please list: _____
  _____
- ☐ Yes ☐ No Have you ever had any complications following dental treatment?
  If yes, please explain: _____
- ☐ Yes ☐ No Have you been admitted to a hospital or needed emergency care during the past two years?
  If yes, please explain: _____
- Name / Phone # of Physician (Required): _____
- ☐ Yes ☐ No Are you now under the care of a physician?
  If yes, please explain: _____
- ☐ Yes ☐ No Do you have any health problems / conditions that need further clarification?
  If yes, please explain: _____
  _____
- ☐ Yes ☐ No Are you taking any medications? Include any over-the-counter supplements/herbal products (i.e. Green Tea, Ginkgo Biloba, etc).

  If yes, please list:

Name of Medication / Reason	Name of Medication / Reason

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

DENTAL INFORMATION

Date of Last Dental Visit: _____ Reason for this visit: _____

Chief Dental Concern: _____

- ☐ Yes ☐ No Are you experiencing any discomfort at this time?

If yes, please explain: _____

- ☐ Yes ☐ No Are you interested in improving the appearance of your smile?

If yes, please explain: _____

Do you have / have you had (please check those that apply):

☐ Unfavorable dental experience	☐ Burning of tongue	☐ Swelling or lumps in mouth
☐ Teeth sensitive to cold, heat, sweets, or pressure	☐ Food impaction	☐ Pain around ear
☐ Unusual sounds in ear while eating	☐ Unpleasant taste	☐ Periodontal treatment
☐ Frequent blisters on lips or mouth	☐ Bad breath	☐ Orthodontic treatment
☐ Bleeding gums	☐ Cold sores	☐ Complications from extractions
☐ Clenching or grinding	☐ Mouth breathing	☐ Pain around ear

Do you use (please check those that apply):

☐ Tobacco products	☐ Dental floss	☐ Water Jet device
☐ Fluoride supplements	☐ Inter-dental supplements	☐ Disclosing tablets or solutions

- Texture of toothbrush: ☐ Extra Soft ☐ Soft ☐ Medium ☐ Hard
- Frequency of Brushing: _____

- ☐ Yes ☐ No Is there anything else about dental treatment that bothers you? _____

_____

To the best of my knowledge, all of the preceding answers to the above sections (Patient, Responsible Party, Employment, Insurance, Health and Dental) and information provided are true and correct. If I ever have any change to this information, I will inform the office at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____

Print name of signature above: _____ Relationship to Patient: _____

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CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the stated fee of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

A fee of $50.00 will be charged for all appointments canceled without 48-hours advance notice.

I grant my permission to you or your assignee, 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 payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ _____ Relationship to Patient: _____
Print Name of Signature above

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HIPAA

Patient Rights... This law is careful to describe that you have the following rights related to your health information. You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications... You have the right to request that we communicate with you in a certain way. You may request that we only communicate health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor our reasonable requests for confidential communications.

Inspect and Copy Your Health Information... You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. A fee will be charged to duplicate and assemble your copy.

Amend Your Health Information... You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information... You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. A fee will be charged for this service.

Request a Paper Copy of this Notice... You have the right to obtain a copy of this Notice of Privacy Practice directly from our office at any time. Stop by or give us a call and will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our policy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Abuse or Neglect... We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security... We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important with the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement... As permitted or required by State or Federal law, we may disclose your health information to law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime in order to report a crime.

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HIPAA (continued)

Family, Friends, and Caregivers... We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important for to those participating in providing your care.

Authorization to Use or Disclose Health Information... Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time. You may revoke that authorization at any time.

Thank you for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ _____ Relationship to Patient: _____
Print Name of Signature above

Beach Family
Cosmetic Dentistry

FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, Mastercard, AMEX and/or Discover. We also offer CARECREDIT, which are financing options that are available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 18.5% per annum after 90 days.

Optional payment terms:

1. For cash patients ONLY without Insurance we offer a 5% accounting courtesy for all services that is paid in full prior to the commencement of services. (cash or check, NO Credit cards)
2. Term Loan: By arrangements with CARECREDIT we can offer patients upon approval, an interest-free term loan (up to 6 months) with no down payment, no annual fee and no prepayment penalty. Ask for an application.

There will be a fee for any additional procedure NOT included in the original treatment plan.

Appointments:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24-hour notice for any cancelled appointment. We reserve the right to charge for any appointment(s) broken without a 24-hour notice. The charge will be $50.00. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January – December)

All of our doctors will diagnose treatment based on your dental health not your insurance coverage.

You must realize that:

Dental insurance isn't really an assurance of payment for a dental treatment since dental insurance's coverage is dictated by the insurance company. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for a tooth that has extensive decay, however, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

_____

Patient's name (please print)

_____

Patient's signature Date

_____

Date

(Financial Coordinator)