SAN RAMON FAMILY DENTAL
DR. RUPAM KHANNA

Patient's Information

Today'sDate:_____/_____/_____LastName:_____FirstName:_____

SS #: _____/_____/_____ Birthday: _____/_____/_____ Age: _____ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Other ☐

Home Address: _____

Home # :(_____) _____/_____ Work# :(_____) _____/_____ Ext:_____ Cell#:(_____) _____/_____

DL#:_____Email Address: _____

Employer's Name/Address: _____Occupation:_____ How Long There: _____

Other Family Members Seen By Us: _____Whom May We Thank For Referring You? _____

Name of Previous/Current Dentist: _____Dentist Phone #: (_____) _____/_____ Last Dental Visit: _____/_____/_____

Name of Medical Physician: _____Physician's Phone#: (_____) _____/_____ Date of Last Visit: _____/_____/_____

Are You Currently under Care of a Physician? Y ☐ N ☐ Please Explain: _____

Neighbor/Relative Not Living With You

His/Her Name: _____ _____Relation: _____ _____Cell #: (_____) _____/_____

Address: _____ Home #: (_____) _____/_____ Work #: (_____) _____/_____

Spouse Information

His/Her Name: _____Employer: _____

Birthday: _____/_____/_____ Work #: (_____) _____/_____ Ext: _____ SS #: _____/_____/_____ DL #: _____

Primary Insurance

Dental Coverage? ☐ Yes ☐ No Insurance Co. Name: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: (_____) _____/_____

Insured's Name: _____ Relation: _____**Insured's** Birthday: _____/_____/_____ **Insured's** ID #: _____

Insured's Employer: _____ Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Insurance Co. Name: _____ Group #: _____

Insurance Co. Address: _____ Insurance Co. Phone #: (_____) _____/_____

Insured's Name: _____ Relation: _____**Insured's** Birthday: _____/_____/_____ **Insured's** ID #: _____

Insured's Employer: _____ Employer's Address: _____

Medical History

Do you smoke or use tobacco products? Yes ☐ No ☐ Do you have any metal rods, pins or implants? Yes ☐ No ☐

Are you currently taking any prescription or over the counter supplements? Yes ☐ No ☐

If yes please list medications: _____

For Woman Only

Are you currently pregnant? Yes ☐ No ☐ Total Weeks #: _____ Are you nursing? Yes ☐ No ☐

Have you ever had any of the following disease or medical problems?

Yes ☐	No ☐	Abnormal Bleeding			
Yes ☐	No ☐	Alcohol/Drug Abuse	Yes ☐	No ☐	High Blood Pressure
Yes ☐	No ☐	Anemia	Yes ☐	No ☐	Hospitalization for any reason
Yes ☐	No ☐	Artificial Bones/Joints/Valves	Yes ☐	No ☐	Kidney Problems
Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Liver Disease
Yes ☐	No ☐	Blood Fusion	Yes ☐	No ☐	Low Blood Pressure
Yes ☐	No ☐	Cancer/Chemotherapy	Yes ☐	No ☐	Lupus
Yes ☐	No ☐	Colitis	Yes ☐	No ☐	Mitral Valve Prolapse
Yes ☐	No ☐	Congenital Heart Disease	Yes ☐	No ☐	Pacemaker
Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Psychiatric Problems
Yes ☐	No ☐	Difficulty Breathing	Yes ☐	No ☐	Radiation Treatment
Yes ☐	No ☐	Emphysema	Yes ☐	No ☐	Rheumatic/ Scarlet fever
Yes ☐	No ☐	Fainting Spells	Yes ☐	No ☐	Seizures
Yes ☐	No ☐	Frequent Headaches	Yes ☐	No ☐	Shingles
Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Sickle Cell Disease/Traits
Yes ☐	No ☐	Hay Fever	Yes ☐	No ☐	Sinus Problems
Yes ☐	No ☐	Heart Attack/Surgery	Yes ☐	No ☐	Stroke
Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐	Thyroid Problems
Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Tuberculosis (TB)
Yes ☐	No ☐	Herpes	Yes ☐	No ☐	Ulcers
Yes ☐	No ☐	Fever Blister	Yes ☐	No ☐	Venereal Disease

Are you allergic to any of the following?

Yes ☐	No ☐	Aspirin	Yes ☐	No ☐	Erythromycin	Yes ☐	No ☐	Penicillin
Yes ☐	No ☐	Codeine	Yes ☐	No ☐	Metals	Yes ☐	No ☐	Tetracycline
Yes ☐	No ☐	Dental Anesthetic	Yes ☐	No ☐	Latex	Yes ☐	No ☐	Other

Please list any other drugs/materials that you are allergic to: _____

Do you like your smile? Yes ☐ No ☐ Does your gums ever bleed? Yes ☐ No ☐ Type of toothbrush bristles? ☐ Hard ☐ Medium ☐ Soft

How many times do you brush in a week? _____ How many times do you floss in a week? _____ Are your teeth sensitive to hot or cold? Yes ☐ No ☐

Have you ever taken Fosamax or bisphosphonate Yes ☐ No ☐ Have you ever taken Phen Phen Yes ☐ No ☐

Have you lost any of your teeth? Yes ☐ No ☐ If yes, please explain: _____

I understand that the information that I have provided today is correct to the best of my knowledge. I understand that this information will be confidential, and I will inform the office if there's any changes in my medical condition.

_____ _____ _____

Signature Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment f services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the release of any information, including the diagnosis and records of treatment rendered to my insurance company

_____ _____

Signature Date

SAN RAMON FAMILY DENTAL
DR. RUPAM KHANNA

3160 Crow Canyon Rd. #100, San Ramon, CA (925) 866-8422
www.sanramonfamilydental.com

Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up to date information and education tools so that you may fully participate in maintaining optimum oral health. Our financial policy to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a complete dental insurance form or proof of insurance at each appointment.

Full payment is due at the time service is provided unless prior payment arrangement has been made. Our office accepts cash, personal check, MasterCard, and Visa.

Return checks and balances older than 60 days may be subject to collection fees and finance charges. Additionally our office will charge you for broken appointments and appointments cancelled without **48-hours advance notice**. It is vital you give our office a 48-hours notice to avoid cancelled appointment charges.

If you have any questions regarding to our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____ _____
Print Name Date

_____ _____
Signature Date

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Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.

Please Review It Carefully

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 April 14, 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 our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you at your next visit. You may request a copy of our Notice at any time.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care and service that you receive. Your health information is contained in a dental record that is the physical property of San Ramon Family Dental.

How We May Use or Disclose Your Health Information

For Treatment

We may use or disclose your health information to a dentist, specialist or other healthcare providers providing treatment to you for:
the provision, coordination, or management of health care and related services by health care providers;
consultation between health care providers relating to a patient/customer;
the referral of a patient for health care from one health care provider to another; or appointment reminders and recall information.

For Payment

We may use and disclose your health information to others for purposes of processing and receiving payment for treatment and services provided to you.
This may include:

- billing and collection activities and related data processing;
- actions by a health plan or insurer to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage
- disclosure to consumer reporting agencies of information relating to collection of payments.

For Health Care Operations

We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of staff to:

- evaluate the performance of our dentists;
- assess the quality of service, product and care in your case and similar cases;
- learn how to improve our facilities and services;
- conduct training programs or credentialing activities; and
- determine how to continually improve the quality and effectiveness of the products, service and care we provide.

Appointments, Treatment and Quality Assurance

We may use your information to provide appointment reminders or recall notices (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits, products and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

To You, Your Family and Friends

We must disclose your health information to you, as described in the Your Health Information Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Required by law

We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence;
- to assist law enforcement officials in their law enforcement duties; or
- to assist public health officials avert a serious threat to the health or safety of you or any other person.

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 anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Health Information Rights

Access

You have the right to review or get copies of your health information, with limited exceptions. You may be asked to make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice setting forth the specific information to which you desire access.

Restriction

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. We support your right to the privacy of your health information.