WHITING FAMILY DENTAL

Patient name: _____ Age_____ Male Female
Date of birth_____ Social security #_____-_____-_____ Married Single Child(under 14)
Address_____ Apt # _____
City_____ State _____ Zip _____
Telephone numbers: Home_____ Work_____ Cell Phone _____
Email Address_____ Best way to contact you_____
Legal guardian name (if Patient is under 18) _____

Emergency Contact_____ Phone # _____

Nearest relative not living with you:
Name_____ Address_____
City/State/Zip_____ Phone#_____

How did you hear about our office?

☐ Friend/Relative (name) _____

☐ Insurance List ☐ Billboard Inyokern Rd ☐ Mailer ☐ Magazine/coupon

☐ Phonebook ☐ Billboard China Lake ☐ Internet

☐ Other (please specify) _____

Please tell us what services you are interested in:

☐Replacing Silver Fillings ☐Having a Whiter Smile ☐Sedation/Sleep Dentistry

☐Tooth Replacement (Implant/Bridge) ☐Smile Makeover ☐Braces/Invisalign®

Please tell us of any other specific dental concerns you may have: _____
_____

CONSENT TO PROCEED: I authorize Whiting Family Dental Doctors or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that I am entering into a contractual relationship with the Whiting Family Dental Doctors for professional care. I further understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare, and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice against Whiting Family Dental Doctors. Furthermore, should a meritorious medical/dental malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this, Whiting Family Dental Doctors agree to the same stipulations.

_____ _____
Signature of Patient, Legal Guardian or Authorized Agent Date

_____ _____
Witness Date

16127 Kasota Rd Suite #103 Apple Valley CA 92307 | Tel 760.242.3223
841 N Downs Suite #C Ridgecrest CA 93555 | Tel 760.375.6999
www.whitingfamilydental.com

WHITING FAMILY DENTAL

FINANCIAL INFORMATION AND POLICIES

Person responsible for this account: _____ Married Single
Address: _____
Driver's License Number: _____ Phone#_____

Is patient covered by dental insurance? Yes or No

Insurance Company Name: _____
Address: _____ City/State/Zip: _____
Telephone# _____
Subscriber's Name _____ Group#_____
Date of Birth: _____ Social Security#_____-_____-_____
Employer Name: _____ Employer Telephone#_____

Is patient covered by secondary insurance? Yes or No

Insurance company name: _____
Address: _____ City/State/Zip: _____
Telephone#_____
Subscriber's Name _____ Group#_____
Date of Birth: _____ Social Security#_____-_____-_____
Employer Name: _____ Employer Telephone#_____

DENTAL INSURANCE is a contract between a patient /guardian and the insurance company and in no way absolves the patient/guardian of full responsibility for the charges incurred. Estimates of insurance payment made by this office are considered a guideline only. We can make no guarantee of the insurance payment(s) estimated. We are pleased to help process insurance forms, help maximize your insurance benefits and are glad to help answer any questions you may have about your treatment or treatment estimates.

SCHEDULED APPOINTMENTS: The time scheduled for your visit is set aside especially for you. We look forward to making your visit pleasant, comfortable and productive. In the unlikely event you are unable to make your appointment; we ask that you give us 24 hours notice so that we may give this time to other patients needing treatment. There will be a charge of $1.00/minute for appointment(s) missed or broken without 24 hours prior notice!

FINANCE CHARGES: A monthly charge of 1.5% (18% annually) will be added to all account balances not paid within 60 days of services. A late fee of $10/month will be assessed to all past due accounts.

I have read, understand and agree to the above policies. In the event of default, I agree to pay all cost of collection as well as court costs and reasonable attorney's fees in the event legal action is taken.

_____ _____
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_____ _____
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WHITING FAMILY DENTAL

MEDICAL HISTORY

Patients Name: _____

Physician's Name: _____ Phone: _____

Have you ever used bisphosphonate medication? Common Names: Fosamax, Actonel, Atelvia, Didronel, Boniva ☐ Yes ☐ No

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding abnormally with		High Blood Pressure	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Extractions or Surgery	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Problems	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Lung Problems	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No		

Allergies ☐Yes ☐No Specify _____

Current Medications: _____

Women

Pregnant ☐ Yes ☐ No Due Date: _____ Nursing ☐ Yes ☐ No On Birth Control ☐ Yes ☐ No

Dental History

Former Dentist: _____ City/State: _____

Date of Last Dental Visit: _____ Date of Last X-rays: _____

Mark "yes" or "no" to indicate if you have problems with any of the following:

Bad Breath	☐ Yes ☐ No	Food Collection in Teeth	☐ Yes ☐ No	Periodontal Disease	☐ Yes ☐ No
Bleeding or Swollen Gums	☐ Yes ☐ No	Grinding Teeth	☐ Yes ☐ No	Sensitivity to Cold/Hot	☐ Yes ☐ No
Cigarette Smoking	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Sensitivity to Sweets	☐ Yes ☐ No
Clicking or Popping Jaw	☐ Yes ☐ No	Mouth Breathing	☐ Yes ☐ No	Sensitivity when Biting	☐ Yes ☐ No
Dry Mouth	☐ Yes ☐ No	Orthodontics	☐ Yes ☐ No	Sores or growths in mouth	☐ Yes ☐ No

How often do you brush? _____ How often do you floss? _____

WHITING FAMILY DENTAL

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

The Dentists at Whiting Family Dental and the patient listed below agree to maintain Privacy of the patient as outlined in the HIPAA form, The Dentists take pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Whiting Family Dental believes this is improper and may not be in the patients' best interest. Accordingly, the Dentists agree not to provide any list to an outside company for marketing anything other than our office or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly. Regardless of legal privacy loopholes, Whiting Family Dental will never attempt to leverage its relationship with patient by seeking patient's consent for marketing products for other companies. In consideration for treatment and the above notes patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Whiting Family Dental or the dentists, expertise and/or treatment- the sole exceptions being communication to a confidential dental-peer review body: to another healthcare provider: to a licensed attorney: to a governmental agency: in the context of a legal proceeding: or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication about Whiting Family Dental and/or our dentists or employees, the patient exclusively assigns all Intellectual Property rights, including copyrights, to Whiting Family Dental for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Whiting Family Dental. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Whiting Family Dental has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon Whiting Family Dental or its dentists: Patient will use all reasonable efforts to prevent any member of their immediate family or acquaintance from, engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage the practice.

Our Dentists feel strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Dentists and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to the patient: or (b) three years beyond any termination of the dentist-patient relationship. As a matter of office policy, Dentists are requiring all patients in the practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all patients.

Patient and Dentists acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, patient and Dentists agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation. Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____

Signature of Patient, Legal Guardian or Authorized Agent Date

_____ _____

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WHITING FAMILY DENTAL

Dental Materials Fact Sheet Acknowledgement

I have received a copy of the Dental Materials Fact Sheet, for my review, as required by law.

Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse To Sign This Acknowledgement

I, _____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing, I am giving my consent to Whiting Family Dental for the use and disclosure of my protected health information to carry out treatment, payment activities, health care operations, and to communicate with specialists and lab technicians who are involved in my treatment.

_____ _____

Signature Date

_____

Print Name

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* * FOR OFFICE USE ONLY * *

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Specify) _____

_____

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