Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type _____ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other _____

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever _____

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis _____

Form #4073 (0304)

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

SAN RAMON FAMILY DENTAL
DR. RUPAM KHANNA

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

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.

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PATIENT ACKNOWLEDGMENT OF RECEIPT
OF NOTICE PRIVACY PRACTICES

I have received a copy of NOTICE PRIVACY PRACTICES.

_____

Patient or Guardian Signature Date

FOR OFFICE USE ONLY
On the date above we made a "good faith effort" to obtain written acknowledgement of the receipt of our NOTICE PRIVACY PRACTICES. We were unable to obtain acknowledgement for the following reason:

☐ Patient refused to sign

☐ Other: _____
(Communication barriers, dental emergency)

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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. ***Repeated cancellations or missed appointments will result in loss of future appointment privileges.***

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