Chart #: _____
FOR OFFICE USE ONLY

Patient Information

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

Social Security #: _____ Birth Date: _____ Gender: Male/Female Married/Single

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Occupation/Employer:_____

Whom may we thank for referring you? _____

Insurance Information

Primary

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

Insured's Birth Date: _____ Insurance Plan Name: _____

Insured's Employer Name: _____ ID#:_____ Group #: _____

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

Secondary

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

Insured's Birth Date: _____ Insurance Plan Name: _____

Insured's Employer Name: _____ ID#:_____ Group #: _____

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

Consent for Services

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Ghibu all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use on all insurance submissions. Dr. Ghibu may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

There will be a $25 cancellation charge per half hour scheduled without a 24 hour notice. All unpaid balances after 60 days will have a $25 late fee applied per month. After 90 days the account will go to collections and will have collections fee of $100 added.

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 reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. 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.

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

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

I acknowledge I have received a copy of the
Dental material facts sheet (initials) _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Have you had:

Bad breath	YES	NO	Jaw pain or tiredness	YES	NO
Bleeding gums	YES	NO	Lip or cheek biting	YES	NO
Blisters on lips or mouth	YES	NO	Loose teeth or broken fillings	YES	NO
Burning sensation on tongue	YES	NO	Mouth breathing	YES	NO
Chew on one side of mouth	YES	NO	Mouth pain	YES	NO
Cigarette, pipe, or cigar smoking	YES	NO	Orthodontic treatment	YES	NO
Clicking or popping jaw	YES	NO	Pain around ear	YES	NO
Dry mouth	YES	NO	Periodontal treatment	YES	NO
Fingernail biting	YES	NO	Sensitivity to cold	YES	NO
Food collection between teeth	YES	NO	Sensitivity to heat	YES	NO
Foreign objects in mouth	YES	NO	Sensitivity to sweets	YES	NO
Grinding teeth	YES	NO	Sensitivity when biting	YES	NO
Gum swollen or tender	YES	NO	Sores or growths in mouth	YES	NO

Health History

Have you ever had any of the following? Please check those that apply:

AIDS	YES	NO	Epilepsy	YES	NO	Pacemaker	YES	NO
Anemia	YES	NO	Excessive Bleeding	YES	NO	Psychiatric Care	YES	NO
Arthritis, Rheumatism	YES	NO	Fainting or dizziness	YES	NO	Radiation Treatment	YES	NO
Artificial Heart Valves	YES	NO	Glaucoma	YES	NO	Respiratory Problems	YES	NO
Artificial Joints, Screws, Pins, etc.	YES	NO	Headaches	YES	NO	Scarlet Fever	YES	NO
			Heart Problems	YES	NO	Shortness of Breath	YES	NO
Asthma	YES	NO	Heart Murmur	YES	NO	Sinus Problems	YES	NO
Back Problems	YES	NO	Hepatitis	YES	NO	Skin Rash	YES	NO
Bleeding abnormally, with extractions or surgery	YES	NO	Herpes	YES	NO	Special Diet/Weight Loss	YES	NO
			Hernia Repair	YES	NO	Stroke	YES	NO
Blood Disease	YES	NO	High Blood Pressure	YES	NO	Swollen Feet or Ankles	YES	NO
Cancer	YES	NO	HIV Positive	YES	NO	Swollen Neck Glands	YES	NO
Chemical Dependency	YES	NO	Jaundice	YES	NO	Thyroid Problems	YES	NO
Chemotherapy	YES	NO	Jaw Pain	YES	NO	Tonsillitis	YES	NO
Circulatory Problems	YES	NO	Kidney Disease	YES	NO	Tuberculosis	YES	NO
Congenital Heart Lesions	YES	NO	Liver Disease	YES	NO	Tumors or Growths	YES	NO
Cortisone Treatments	YES	NO	Nervous Disorder	YES	NO	Ulcers	YES	NO
Cough, persistent or Bloody	YES	NO	Mitral Valve Prolapse	YES	NO	Venereal Disease	YES	NO
Diabetes	YES	NO	Osteoporosis	YES	NO			

Have you ever taken:

Blood thinners	YES	NO
Coumadin	YES	NO
Warfarin	YES	NO
Fosamax	YES	NO
Levoxyl	YES	NO
Synthroid	YES	NO

Are you allergic to:

Aspirin	YES	NO
Barbiturates	YES	NO
Codeine	YES	NO
Ibuprofen	YES	NO
Latex	YES	NO
Local anesthesia	YES	NO
Metals (i.e. gold)	YES	NO
Penicillin	YES	NO

Other _____

Have you ever had any complications following dental treatment?

YES NO

If yes, please describe:

_____

_____

Have you ever been hospitalized or do you have any other concerns?

YES NO

If yes, please describe:

_____

_____

Women:

Are you pregnant? YES NO

Due date: _____

Are you nursing? YES NO

Please print all medications you are currently taking:

_____

_____

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Signature of Doctor

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Sandy Ghibu, D.D.S.
Orest Frangopol, D.D.S.
24401 Ridge Route Dr. #107-A
Laguna Hills, CA 92653