James M. Everhart, D.D.S.
9399 Madison Ave.
Orangevale, CA 95662

E-mail_____

Patient Information

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

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____(Cell)_____Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____
Reason for today's visit: _____

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

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease/Disorder
☐ Blood Thinners
☐ Bruise Easily
☐ Cancer
☐ Chicken Pox
☐ Cold Sores/Fever Blister
☐ Connective Tissue Disorder
☐ Contact Lenses
☐ Cortisone Medication
☐ Diabetes
☐ Diet (Special/Restricted)
☐ Digestive Track Problem
☐ Dizziness
☐ Eating Disorder
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ H.I.V. Positive
☐ Head Injuries
☐ Hearing Loss
☐ Heart Disease / Surgery
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis A, B, or C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Latex Sensitivity
☐ Liver Disease
☐ Lung Problems
☐ Malaria
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Psychiatric Care
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Recurrent Headaches
☐ Recurrent Ear Infections
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizure Disorder
☐ Sinus Problems
☐ Smoke/Chew Tobacco
☐ Spinal Cord Disruption
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors/Cysts
☐ Ulcers
☐ Venereal Disease
☐ Visual Problems
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
- _____
- _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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

I have received a copy of the booklet "Facts about Fillings."_____Date:_____

Signature of patient or guardian

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Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Banner ☐ Other _____

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

Please fill out this form as completely and accurately as possible.

Current Medication List

Medication / Dosage	Reason

Patient Name: _____

Patient Signature: _____

Date: _____

Spouse or 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: _____

_____

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 reasonable value 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.

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

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

Financial Policies

We strongly feel that our patients deserve the best possible care we can provide. In an effort to provide and maintain this high quality care, we would like to share some information with you about financing your dental care. Our hope is that by providing you with the following information we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us. We urge you to consult with us if you have any questions.

1. At your first visit we ask that you make payment in full for this appointment. If you have dental insurance, we ask that you pay your portion in full.
2. After your first visit, we ask that you make payment in full unless other arrangements have been made. You must sign an agreement form before treatment begins. If you have dental insurance we ask that you pay your portion in full.
3. Visa, MasterCard, ATM & Discover may be used for payment of your account.
4. Outstanding account balances are due in full within 45 days unless other arrangements have been made. A finance charge of 1.5% (18% per year) will be assessed to balances over 90 days past due.

WE ENCOURAGE YOU TO CHECK WITH YOUR INSURANCE COMPANY IF THEY HAVE NOT MADE PAYMENT WITHIN 30 DAYS!

5. Many patients are under the illusion that if they have insurance coverage, it is the insurance company who owes Dr. Everhart payment for services rendered. The insurance contract is **between the patient and the insurance company.** Therefore, the patient is responsible for all account balances regardless of their insurance benefits. We will gladly assist you by sending completed claim forms to your insurance company. Please be sure to provide us with correct information so that we may process your claim in a timely manner.
6. Many insurance companies state that that the provided services will be covered for "Up to 50%, 80%, or even 100%." We have found that many plans cover less than that depending upon the plan's established "**usual and customary fees**." Insurance companies use "usual and customary" when establishing **fee limitations** for services rendered and are usually determined by *percentile* of an area. The benefits paid by your plan are largely determined by how much your employer/union paid for the plan. Please be aware that some insurance companies will pay a claim percentage based on *their "usual and customary"* fees and not *our* actual fees. Thus, your insurance company coverage may be less that you want or expect. Our office does not guarantee payment or the amount that your insurance may pay. Our office will not enter into a dispute with an insurance company regarding deductibles, co-payments, covered charges, "usual and customary" fees etc.
   We do cooperate fully with insurance regulations guidelines.

   WE ENCOURAGE YOU TO BE FAMILIAR WITH YOUR PLAN BENEFITS!

7. We do not routinely send predetermination to your insurance carrier. We have found that this is merely a tactic by the insurance company to delay needed treatment by as much as 3 months **and is not a guarantee of payment**.
8. The parent that brings in a minor for treatment and signs as the guarantor is responsible for payment of services rendered. Our office does not recognize agreements between parents accepting or denying financial responsibility for dental fees.
9. **Delinquent accounts** will be referred to collection at the discretion of the business manager. There will be a $75.00 processing fee for those accounts referred to collections. There is a $75.00 charge for all checks returned for non-sufficient funds.
10. **We reserve the right to charge a broken appointment/late cancellation fee of up to $250.00 per hour with less than 24 hour notice. We do request 48 hours notice for changes to our schedule.**
11. We reserve the right to check credit histories of guarantors.
12. Any photos taken are available for Dr. James Everhart, D.D.S. to use in publication, lecture or in a teaching environment without compensation to the patient. These photos and/or radiographs will remain anonymous.

13. To ensure your records are current please notify us of any changes related to your medical history, phone number, address, employer or insurance carrier information as soon as they occur.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to James Everhart, D.D.S. I also authorize Dr. Everhart to release any information required to process claims in their entirety.

I understand that I am ultimately responsible for any balances due.
I have read and understand the policies as outlined above.

Signed_____**Date**_____

Signature of Dr. or Representive_____Date_____

James M. Everhart D.D.S., Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:

James M. Everhart DDS
Phone: 916-988-0300 Fax: 916-988-3232
9399 Madison Ave. Suite 104
Orangevale, CA 95662

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

James M. Everhart D.D.S., Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 04/14/03, 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient 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.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must 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. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Getting to Know You .....

James M. Everhart D.D.S
General & Cosmetic Dentistry

Telephone: 916-988-0300
Fax: 916-988-3232
9399 Madison Avenue,
Orangevale, CA 95662
www.everhartdentistry.com

Patient Name _____ Date_____

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive care to enhance your smile, improve and maintain your dental function, and help you to prevent future dental problems."

To help us serve your dental needs best, we would like to know more about you. Please take a moment to complete the following questions:

What do you expect from your visit with us today?

_____

_____

What is most important to you about your dental health?

_____

In your opinion, what is the present condition of your mouth?

_____

What would you like your teeth to be like in 10 or 20 years?

_____

Are you aware that there are medical conditions related to dental disease?

_____

What do you know about periodontal disease?

_____

If you could "enhance" anything about your smile what would it be?

_____

Are there foods you enjoy but cannot eat due to discomfort with your teeth?

_____

What has been your overall experience in other dental offices?

_____

Has "fear" or "cost" ever prevented you from getting the dental treatment you need? Y__N__ or Want? Y___N___ Please explain:_____

_____

What "quality" of dentistry do you want us to focus on at this time? Please circle:

A) Patch It **B)** Only what is covered by insurance **C)** Ideal / Best

Should you be in need of treatment at what point do you plan to "get started"? Please circle:

A) When it hurts **B)** When it breaks **C)** When it is recommended in order to prevent further deterioration

Please feel free to let us know more about how we can help make this your best dental experience.

_____

_____

(For internal use only)