



Thank you very much for placing your trust in our office and we would like to extend a whole hearted WELCOME to you and your family. Choosing the right doctor and practice is an important decision and we appreciate you instilling your trust in us. As your new dental home, we strive to provide "concierge level care at a comfortable cost". A place you enjoy coming to; a warm feeling of comfort and ease knowing that we will take care of you like you are a member of our extended family.

Our mission statement first and foremost is:

"...to serve our patients in a calm, comfortable atmosphere of trust and compassion. We are driven to be the best, love what we do and want you to feel good about visiting us. We strive to build long term relationships through quality dental care and are passionate about improving the health and wellness of our patients. Additionally, dentistry is not only the act of providing care, but also being an active community member through volunteer and support of local causes. We wish for a better life for everyone involved."

We have been in family practice for the last fifteen years and have a strong background in family and geriatric (senior) care providing all aspects of general dentistry. Our goal is not to create a production oriented practice where the doctor jumps from room to room. We will take the time to explain treatment options and procedures, and ensure all questions are answered prior to treatment. We are a team and can reach dental health together. Having proudly served with the US Navy as a dentist in Japan, Dr Beck also has experience treating fearful, PTSD and TMD/TMJ patients. Whether it is in the office, after hours or over the weekend, we are here to provide excellent care, ease concern and answer your questions whenever the need is there.

For your convenience, we have enclosed a health questionnaire and other pertinent new patient information. Please bring the enclosed forms (filled out) with you to your scheduled appointment and if you have any questions, feel free to call us at 949.396.3803. We look forward to meeting you and serving your dental needs now and in the future.

Very Respectfully,

Drs. Joseph Passamano and Melinda Beck

NEW PATIENT INFORMATION

Name: _____ Sex: M F DOB _____
Please Print First Middle Initial Last mm/dd/yyyy

Street Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Employer: _____ Occupation: _____ SS#: _____
Name of business if self-employed / if retired, previous occupation Type of business if self-employed

Person to contact in case of emergency: _____
Name Phone number

Address _____ Relationship _____

Financially Responsible Party Information: (if you are a college student, please fill out information with parents as the responsible party)

Name: _____ Relationship to patient: _____ DOB: _____
mm/dd/yyyy

Mailing Address: _____

Billing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____ SS#: _____
Name of business if self-employed / if retired, previous occupation Type of business if self-employed

Insurance: Primary Dental Insurance _____
Insurance Company Name

Employee Name: _____ Employee DOB: _____
mm/dd/yyyy

Relationship to Patient: _____ Employee SS#: _____

Insurance ID#: _____ Group ID#: _____

Employer: _____

Employer Address: _____

Insurance: Secondary Dental Insurance _____
Insurance Company Name

Employee Name: _____ Employee DOB: _____
mm/dd/yyyy

Relationship to Patient: _____ Employee SS#: _____

Insurance ID#: _____ Group ID#: _____

Employer: _____

Employer Address: _____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all form of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. **I agree to pay for all services rendered by this office.**

Signature Relationship to Patient Date

Printed Name of Patient or Guardian

Medical History

Patient Name _____ DOB _____
Please Print First Middle Initial Last mm / dd / yyyy

Physician _____ Physician Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Yes No Are you under a physician's care now? If yes, please explain: _____
- Yes No Have you ever been hospitalized or had a major operation? If yes, please explain: _____
- Yes No Are you taking any medications, pills or drugs? If yes, please list current medications: _____
- Yes No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
- Yes No Are you on a special diet?
- Yes No Do you use tobacco?
- Yes No Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex
 Sulfa drugs Other If yes, please explain _____

Do you have, or have you had, any of the following? Please circle correct response.

AIDS/HIV Positive	Yes	No	Congenital Heart Disorder	Yes	No	Heart Attack/Failure	Yes	No
Alzheimer's Disease	Yes	No	Convulsions	Yes	No	Heart Murmur	Yes	No
Anaphylaxis	Yes	No	Cortisone Medication	Yes	No	Heart Pacemaker	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Heart Trouble/Disease	Yes	No
Angina	Yes	No	Drug Addiction	Yes	No	Hemophilia	Yes	No
Arthritis/Gout	Yes	No	Easily Winded	Yes	No	Hepatitis A	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Hepatitis B or C	Yes	No
Artificial Joint	Yes	No	Epilepsy or Seizures	Yes	No	Herpes	Yes	No
Asthma	Yes	No	Excessive Bleeding	Yes	No	High Blood Pressure	Yes	No
Blood Disease	Yes	No	Excessive Thirst	Yes	No	High Cholesterol	Yes	No
Blood Transfusion	Yes	No	Fainting Spells/Dizziness	Yes	No	Hives or Rash	Yes	No
Breathing Problem	Yes	No	Frequent Cough	Yes	No	Hypoglycemia	Yes	No
Bruise Easily	Yes	No	Frequent Diarrhea	Yes	No	Irregular Heartbeat	Yes	No
Cancer	Yes	No	Frequent Headaches	Yes	No	Kidney Problems	Yes	No
Chemotherapy	Yes	No	Genital Herpes	Yes	No	Leukemia	Yes	No
Chest Pains	Yes	No	Glaucoma	Yes	No	Liver Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Hay Fever	Yes	No	Low Blood Pressure	Yes	No

Lung Disease	Yes	No	Rheumatism	Yes	No	Thyroid Disease	Yes	No
Mitral Valve Prolapse	Yes	No	Scarlet Fever	Yes	No	Tonsillitis	Yes	No
Osteoporosis	Yes	No	Shingles	Yes	No	Tuberculosis	Yes	No
Pain in Jaw Joints	Yes	No	Sickle Cell Disease	Yes	No	Tumors or Growths	Yes	No
Parathyroid Disease	Yes	No	Sinus Trouble	Yes	No	Ulcers	Yes	No
Psychiatric Care	Yes	No	Spina Bifida	Yes	No	Venereal Disease	Yes	No
Radiation Treatments	Yes	No	Stomach/Intestinal Disease	Yes	No	Yellow Jaundice	Yes	No
Recent Weight Loss	Yes	No	Stroke	Yes	No			
Renal Dialysis	Yes	No	Swelling of Limbs	Yes	No			

Have you ever had any serious illness not listed above? Yes No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient, Parent, or Legal Guardian _____ Date _____
 (For Digital forms your printed name acts as your signature)

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History has been reviewed and verified by the doctor. All questions and concerns have been answered.

Signature _____ Date _____



DENTAL HISTORY

Name: _____

Primary reason for this dental appointment: Examination Emergency Consultation

PLEASE CIRCLE

Yes No 1. Do you have a dental problem or concern? _____

Yes No 2. Do you receive routine dental care?
Last visit _____
Treatment received _____
Last cleaning _____
Last x-rays _____

Yes No 3. Are you aware of any sores or growths in your mouth?

Yes No 4. Do your gums bleed?
5. How frequently do you brush? _____
When? _____
6. How often do you floss? _____

Yes No 7. Do you have sensitive or sore teeth?
To what? _____

Yes No 8. Does food catch between your teeth?

Yes No 9. Do you have loose teeth?

Yes No 10. Do you have frequent earaches or headaches?

Yes No 11. Are you unhappy with the appearance of your teeth?

Yes No 12. Have you lost any teeth?
Why? _____

Yes No 13. Were missing teeth replaced?
When? _____

Yes No 14. If teeth were not replaced, have you had problems with your appearance, or with chewing? _____

Yes No 15. Do you have dentures?
How many sets have you had? _____

Yes No 16. Have you ever had problems or complications with past dental care? _____

Yes No 17. Does your mouth feel dry?

Yes No 18. Do you often consume sweets?
 Candy/Mints/Gum Soda Pop
 Coffee/Tea with sugar Cough Drops

Yes No 19. Do you clench or grind your teeth (day/night)?

Yes No 20. Do you have problems chewing any type of food?

Yes No 21. Do you have any other questions or concerns about dentistry or your health? *(Please describe)* _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date _____

Financial Policy

Thank you for choosing us for your dental health care. Your dental health is our first priority and we are committed to successful dental treatments for you and your family. It is our belief that patients should make informed decisions about their dental health care. Proper financial arrangements are vital to our success in delivering top quality dental care. The following is a statement of our financial policy, which **we require you read and sign prior to any treatment.**

Financial Policy

Prior to initiating any treatment, we will inform you of your financial status with our office. This will include providing you with an estimate of the cost of your treatment. When a significant amount of work is planned, we will provide you with a typewritten estimate, which will also include the amount we **anticipate** your insurance company will assist with. We invite you to call our office or stop by with any questions that you might have.

We wish to schedule your treatment at a pace that is financially comfortable to you. Occasionally, patients will request that work be spread out over months or even years. While this is acceptable in many cases, be aware that your oral health can change significantly in a relatively short amount of time. Therefore, regular comprehensive examinations (with x-rays as needed) will be performed.

Please take a moment to review the current financial options available through our office. Should you need assistance with financial options at any time, our team will be available to assist upon your request.

Payment Options

1. Payment in full is due on the day of each visit. To demonstrate our appreciation for patients who are prompt with full payment, we will extend a three percent (3%) reduction in the total fee when payment is received in the form of cash or check.
2. Payments may be available for treatment and patients who qualify
3. We require that all insurance co-pays be paid at time of service. As a courtesy, we will bill your insurance for services rendered. To do so, we must receive an updated copy of your insurance card at your first appointment. If necessary, we will submit a pre-determination of benefits request to your insurance carrier prior to treatment. This allows us to obtain an estimate of your dental benefits and an estimated amount your dental plan expects you to be responsible for. **While we help you in every way possible to obtain your maximum allowable insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us. Billing your insurance is done as a courtesy. Knowing your insurance benefits and any balance not paid by the insurance company remains your responsibility.**
4. Secondary Insurance: Having more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. We will gladly bill your secondary carrier. **Any balance not paid by your secondary insurance carrier remains your responsibility.**
5. For all appointments after 01 MAY 2020, there will be an additional \$15 fee to cover increased requirements for Personal Protective Equipment and safety measures per OSHA and CDC guidance. This will be billed to your insurance and may be covered on an individual insurance and paid plan basis. Any non-covered expenses will be patient's financial responsibility.

Please remember that we are not a lending institution and any account that is 90 days past due from the original date of service will incur an eighteen percent (18%) annual interest rate.

A fee of fifty dollars (\$50) will be charged for short notice cancellations (less than 24 hours) and missed appointments.

A thirty-five dollar (\$35) fee will be charged for all returned checks.

Usual and Customary Rates

We are committed to delivering the best quality dental treatment for our patients, and we charge what is usual and customary for our area.

I hereby authorize release of any information to my insurance carrier regarding my treatment. I also hereby authorize any insurance benefits otherwise payable to me to be paid directly to Beck Passamano Dental Group for services provided. By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Policy. This agreement stays in force until I change it is writing.

Name of Patient or Responsible Party

(Please Print)

Signature of Patient or Responsible Party (for digital forms your printed name acts as your signature)

Date



How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____

Check or complete all that apply (please print clearly):

Contact me by U.S. Mail at the following address: _____

Contact me by email at the following email address: _____

For Phone and Text Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: _____

By checking this box, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

Call me

Text me

Call me and text me

Signature: _____ Date: _____

Please call the dental office right away if you get a new telephone number!

For Office Use Only:

Consent revoked. Date/Initials: _____/_____

Possible reassigned number. Date/Initials: _____/_____

Confirmed accurate. Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____

Date/Initials: _____/_____ Date/Initials: _____/_____



Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the office's Notice of Privacy Practices.

Print Name

Signature (for digital forms your printed name acts as your signature)

Date

Do we have your permission to:

- | | | |
|--|------------------------------|-----------------------------|
| Leave a message on your answering machine | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Confirm appointments | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Remind you of your pre-med (if applicable) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Speak to household members concerning your dental care | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Name of persons

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices; however, acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

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 the Notice while it is in effect. This Notice takes effect 12/01/02, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 list at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your 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 for you.

Healthcare Operations: We may use and disclose your health information for treatment, payment or healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professional, 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 healthcare information or to disclose it to anyone for any purpose. If you grant us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us 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 of location) 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are 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 institutions or law enforcement officials 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: We 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 from our front desk personnel. We will charge you a reasonable cost-based fee for expenses such as copies, staff time, and postage if you request to have your health information mailed to you. If you request an alternative format, summary, or an explanation of your health information it will be provided at a reasonable cost-based fee.)

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 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.

Restrictions: You have the right to request that we place additional restrictions on our use of 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 the Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the complaint form available at our front desk. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.