CONCIERGE
DENTISTRY

11980 San Vicente Boulevard Suite 507 Los Angeles, California 90049
(310) 820 — 0123

Doctors Grossman & Danesh

Welcome to our practice! Dental care is more than repair. It is maintaining your optimum dental health by restoring your teeth so that they are comfortable, functional and attractive; and by treating your gum tissue as needed to maximize health and vitality to last your lifetime. We will also evaluate your general health and habits that may affect your future dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments that you might have. The more we know about your needs and concerns, the better we can serve you. Thank you!

This office practices state-of-the-art sterilization.
We DO NOT discriminate.

Please note there are SIX signatures needed, and they are highlighted in yellow for easy identification.

Today's Date: _____ Who may we thank for referring you? _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

Drivers License Number: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____

Birth Date: _____ Age: _____ Gender: ☐ Female ☐ Male

Marital Status (married, divorced, single, in relationship, etc.): _____ Children / Ages: _____

Occupation: _____ Employer: _____

Address: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How do you prefer to be contacted? ☐ Home ☐ Work ☐ Mobile ☐ Email

CARECREDIT

Account Number: _____ Credit Line: _____

FOR INTERNAL USE ONLY

CONCIERGE DENTISTRY

DENTAL INSURANCE INFORMATION

Dental Insurance Company: _____

Group Number: _____ Insurance Company Phone Number: _____

IF THE PATIENT IS NOT THE INSURED, POLICY HOLDER INFORMATION

Insured's Name (First and Last): _____

Insured's SSN: _____ Phone Number: _____ Email: _____

Address: _____

Insured's Date of Birth: _____ Insured's ID Number: _____

MEDICAL INSURANCE INFORMATION

Medical Insurance Company: _____

Group Number: _____ Insurance Company Phone Number: _____

IF THE PATIENT IS NOT THE INSURED, POLICY HOLDER INFORMATION

Insured's Name (First and Last): _____

Insured's SSN: _____ Phone Number: _____ Email: _____

Address: _____

Insured's Date of Birth: _____ Insured's ID Number: _____

AUTHORIZATION TO RELEASE INFORMATION; I HEARBY AUTHORIZE

Concierge Dentistry to:
(1) Release any information necessary to insurance carriers regarding my illness and treatments;
(2) Process insurance claimes genreated in the course of examination or treatment; and
(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

On behalf of my self and/or my dependents, and understand that by making this request, I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to Concierge Dentistry.

A photocopy of this assignment is to be considered as valid as the original.

Patient Name or Patient's Guardian if applicable (Please Print): _____

Patient Name or Patient's Guardian if applicable Signature: _____ Date: _____

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Last Name: _____ First Name: _____ MI: _____

Physician Name: _____ Physician Phone Number: _____

	Y	N		Y	N
Hospital or Serious Illness in Last 5 Years	☐	☐	Pace Maker	☐	☐
AIDS / Other Immunosuppressive Disorders	☐	☐	Women: Pregnant	☐	☐
Allergies / Asthma	☐	☐	Due Date		_____
Arthritis, Rheumatism	☐	☐	Nursing	☐	☐
Artificial heart Valves	☐	☐	Psychiatric Care / Treatment	☐	☐
Artificial Joints	☐	☐	Radiation Treatment	☐	☐
Abnormal Bleeding w Extractions / Surgery	☐	☐	Rheumatic Heart Disease	☐	☐
Cancer	☐	☐	Scarlet Fever	☐	☐
Chemical Dependency	☐	☐	Sinus Trouble	☐	☐
Chemotherapy	☐	☐	STD / Venereal Disease	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Epilepsy, Fainting, or Seizures	☐	☐	Swollen Glands	☐	☐
Glaucoma	☐	☐	Thyroid Disorder	☐	☐
Headaches	☐	☐	Tonsillitis	☐	☐
Heart Murmur / Heart Disorder	☐	☐	Transfusion	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
Herpes	☐	☐	Tumor or Growth on Neck or Head	☐	☐
High Blood Pressure	☐	☐	Ulcers	☐	☐
Low Blood Pressure	☐	☐	Unexplained Weight Loss	☐	☐
Kidney Disease	☐	☐	Have you even taken Fen-Phen	☐	☐
Any Operations in Last 5 Years	☐	☐	Latex Allergy	☐	☐
Liver Disease	☐	☐			

List any medications you are currently taking: _____

_____

Any known allergies: _____

_____

Pharmacy Name: _____ Phone Number: _____

To the best of my knowledge, the questions on this form have been understood by me and accurately answered. I understand that providing incorrect information can be dangerous to my health. It is MY RESPONSIBILITY to inform the dental office of any changes in my medical status. I will NOT hold my Dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Dentist Signature: _____

Date: _____ Date: _____

CONCIERGE DENTISTRY

Last Name: _____ First Name: _____ MI: _____

Former Dentist: _____ Former Dentist Phone Number: _____

Reason for today's visit: _____

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

Indicate if you had or are currently aware of any of the following:

	Y	N		Y	N
Bad Breath	☐	☐	Partner Snoring	☐	☐
Bleeding Gums	☐	☐	Food Collection Between Teeth	☐	☐
Blistering on Lips or Mouth	☐	☐	Grinding Teeth / Clenching	☐	☐
Missing Teeth	☐	☐	Gums Swollen / Tender	☐	☐
Cigarette Smoking	☐	☐	Loose Teeth / Broken Filling	☐	☐
Clicking or Popping Jaw	☐	☐	Orthodontic Treatment	☐	☐
Dentures / Partial Dentures	☐	☐	Periodontal Treatment	☐	☐
Dry Mouth	☐	☐	Sensitivity to Heat or Cold	☐	☐
Finger Nail Biting	☐	☐	Sores or Growths in Mouth	☐	☐
Snoring	☐	☐	When it comes to dental care and treatment do you consider yourself proactive or reactive?	Proactive ☐	Reactive ☐

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

Are you satisfied with the brightness of your teeth? _____

Are your teeth straight enough for you? _____

Are you satisfied with your smile? _____

To avoid any misunderstanding regarding your dental insurance, we wish our patients to know that **all professional services are charged directly to the patient and that patients are personally responsible for payment of fees**. We do not render services on the basis that the insurance companies will pay our fees. We will assist you in filing all insurance forms. **Payment is due when services are rendered unless other arrangements have been made**. Our policy for missed appointments or appointments cancelled with less than 48 hours notice is as follows: $100 or 10% of that day's scheduled treatment, whichever is higher. We appreciate the opportunity to serve you and hope you understand our implementation of cost controls such as these.

I herby authorize Concierge Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental condition. I also authorize the Doctor to perform/prescribe any and all forms of medication and therapy that may be indicated and agreed upon.

I understand that all balances over 30 days are subject to a 1.5% monthly service fee.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement. I understand that responsibility for payment for dental services provided in this office for me or my dependents is mine, due and payable, at the time services are rendered.

Patient Signature: _____

Date: _____

Dentist Signature: _____

Date: _____

CONCIERGE DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Last Name: _____ First Name: _____ MI: _____

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. **We will never sell or disclose your personal information to outside parties.** We may use personal information for Dental and Medical Insurance claims and collection activities.

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:

Theresa Kimbro, Office Manager
Telephone: 310-820-0123
Fax: 310-207-3784
Email: dentaloffice@drjaydds.com
Address: 11980 San Vicente Blvd., Suite 507 Los Angeles, CA 90049

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.

Assignment & Release of Information of Medical Benefits: I hereby assign all medical and surgical benefits to which I may be entitled to Concierge Dentistry. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to “Concierge Dentistry":

I hear-by authorize:
(1) Release any information necessary to insurance carriers regarding my illness and treatments;
(2) Process insurance claims generated in the course of examination or treatment; and
(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. On behalf of myself and/or my dependents, I understand that by making this request, I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to: Concierge Dentistry

A photocopy of this assignment, and a copy of my medical card is to be considered as valid as the original.

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 heath 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: _____

CONCIERGE DENTISTRY

MEDICAL HISTORY UPDATE

Updated Health History — This section is for FUTURE updates, please do NOT sign at this time.

Patient Signature: ______________________ Dentist Signature: ______________________

Date: ______________ Date: ______________

Changes: ____

____

____

Updated Health History — This section is for FUTURE updates, please do NOT sign at this time.

Patient Signature: ______________________ Dentist Signature: ______________________

Date: ______________ Date: ______________

Changes: ____

____

____

Updated Health History — This section is for FUTURE updates, please do NOT sign at this time.

Patient Signature: ______________________ Dentist Signature: ______________________

Date: ______________ Date: ______________

Changes: ____

____

____

Updated Health History — This section is for FUTURE updates, please do NOT sign at this time.

Patient Signature: ______________________ Dentist Signature: ______________________

Date: ______________ Date: ______________

Changes: ____

____

____

Updated Health History — This section is for FUTURE updates, please do NOT sign at this time.

Patient Signature: ______________________ Dentist Signature: ______________________

Date: ______________ Date: ______________

Changes: ____

____

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CONCIERGE DENTISTRY

RISKS & POLICIES FOR DENTAL CARE AT OUR OFFICE

RECORDS: I authorize Dr. Grossman & Associates, or staff, to take digital images, models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize email communications at the email address I provided.

CHANGE IN TREATMENT PLAN: During treatment it may be necessary to change the original treatment plan due to conditions found while working that were not discovered during exam. The most common is the need for a root canal on a tooth that is being prepared for a crown.

FILLINGS: Dental fillings may require additional treatment, such as root canals or crowns.

DENTAL CLEANINGS: Deep cleanings in particular may result in sensitivity that mostly resolves in a few days, or may need a periodontal referral if not resolved.

COSMETIC PROCEDURES: May result in exposed nerves or sensitivity that may require root canals. Veneers have a chance of falling off and may require re-cementation, or a change to a full crown. If a veneer fails within the first year, we will replace it at no charge. If it fails in year 2 or 3, there will be a nominal charge of $500 per tooth to restore it. In short, we warranty our veneers for the first 3 years providing you keep **all three of your dental re-care** cleaning appointments annually.

ROOT CANALS: Complications include a broken instrument inside the canal that we cannot retrieve, or a fractured root, and may require re-treatment or extraction.

CROWNS / BRIDGES: Sometimes it is difficult to get an exact color match so we may need to refer you to the lab for a custom color selection. Sometimes porcelain may chip on a crown or the glue no longer holds. If a crown or bridge fails within the first year, we will replace it at no charge. If it fails in year 2 or 3, there will be a nominal charge of $500 per tooth to restore it. In short, we warranty our crowns for the first 3 years providing you keep **all three of your dental re-care** cleaning appointments annually.

CONFIDENTIALITY & PUBLIC POSTING POLICY

"Concierge Dentistry and you, the Patient, understand that all matters relating to treatment and care provided are confidential. Therefore, Patient agrees to promptly address any and all concerns relating to Patient's treatment directly to Concierge Dentistry who will make every effort to promptly resolve any such concerns with Patient to the extent possible. Patient further agrees not to publicize any concerns relating to treatment provided to Patient by Concierge Dentistry without, at a minimum, first providing Concierge Dentistry an opportunity to resolve the concerns. This provision in no way is intended to limit or prevent the Patient from making any formal administrative complaints to any relevant governmental or regulatory entity.

Patient further agrees that should the Patient publicize any complaints or concerns in any forum (i.e. internet websites, blogs, chat groups, newspapers, etc.), Patient shall be deemed to have expressly waived confidentiality relating to treatment with Concierge Dentistry. Should Patient publicize any complaints or concerns relating to treatment and care provided by Concierge Dentistry, Concierge Dentistry shall have the right to publicly respond to any complaints or concerns published by Patient in any forum. Patient further agrees that Patient's election to publish any complaints or concerns in any forum shall constitute a waiver of Patient's rights under the Health Insurance Portability and Accountability Act (HIPAA), to the extent such Act applies to treatment and care provided by Concierge Dentistry to Patient."

Signature of patient: I have reviewed the risks, benefits, and options of the dental procedures and agree to the confidentiality and public posting policy.

Patient Signature: _____ Date: _____

CONCIERGE
DENTISTRY

FINANCIAL AGREEMENT

Thank you for choosing Concierge Dentistry as one of your health care providers. We are pleased to be able to render services in the evaluation and treatment of your dental health.

Please note that Dr. Grossman is the owner, and the other providers are independent contractors.

We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered. If you are unable to provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We will submit your claims to your insurance as a courtesy and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please understand that you will be financially responsible for charges that are not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

If you do not have insurance, payment is due in full at the time of service.

Co-payments, deductibles and non-covered services are due at the time of service. Full payment for any known outstanding balance may be due at the time of your visit. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All other payments are expected within 30 days of receipt of our billing statement.

We are committed to providing the best diagnosis and highest quality of treatment possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours at (310) 820-0123, and speak with Sara, Theresa or LeNai.

MEDICARE We do NOT accept Medicare assignment.

PPO We are providers for many insurance plans, but not all plans. You are responsible for verifying that we are providers for your plan. If you are a PPO member, you are responsible for co-payments, deductibles, and co-insurance at the time of treatment. Please confirm with your insurance that we are providers covered under your plan. If there are changes to your insurance eligibility, it is your responsibility to make sure we have your new insurance information or your services will be your responsibility. Co-payments and deductibles are determined by your plan and are not something we can negotiate.

FINANCIAL AGREEMENT I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees. I understand that if the office agrees to bill insurance as a courtesy, I must submit information when needed and in a timely manner, to ensure that payment is made for services rendered. I understand that I am ultimately responsible for payment of all services.

CREDIT CARD AUTHORIZATION Our office requires that a credit card be kept on file for payment of any co- payment, co-insurance, deductible, or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information. The patient will receive 2 statements and a final notice. If these go unpaid or unanswered within 60 days, the patient will receive a courtesy phone call. If no payment is received, the balance on the account will be charged to the credit card on file.

I acknowledge and authorize Concierge Dentistry to charge the credit card on file, for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 60 days after I receive statements. I agree to receive billing statements, invoices and receipts via the street address and/or email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

Patient Name or Patient's Guardian if applicable (Please Print):

Patient Name or Patient's Guardian if applicable Signature: _____ Date: _____

Credit Card Number: _____ Exp Date: _____ CVC: _____ Billing Zip: _____