Welcome to Dr. Cabebe's Dental Office! We are complimented that you selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office?_____

Date_____ Patient'Name_____
Last First M.I.

Address _____
Street City State Zip

Home Ph.# _____ Work Ph.#_____ Cell#_____

E-Mail Address_____ Soc.Sec.#_____/_____/_____ Drivers Lic.#_____

Birthday ____/____/____ Sex: M F Married ___ Divorced ___ Separated ___ Widowed ___ Single___

Employer _____ Occupation _____

Spouse's Name _____ Work Ph.# _____

Name of nearest relative not living with you _____ Relationship _____

Relative Address _____ Ph.# _____

Emergency Contact _____ Ph.# _____

Responsible Party Information

Name_____ Birthday _____/_____/_____
Last First M.I.

Address_____
Street City State Zip

HomePh.#_____ WorkPh#_____ Cell#_____

Soc. Sec.# _____/____/_____ Relationship to Patient _____

Employer _____ Occupation _____

Insurance Information

Insured Employee's
Name _____ Birthday_____/_____/_____ Soc. Sec.# _____/_____/_____

Insurance Company _____ Group# _____

Insurance Co. Address _____ Ph.# _____

Do you have dual coverage? Yes ___ No ___ If yes, please complete the following secondary insurance information:

Insured Employee's
Name _____ Birthday_____/_____/_____ Soc. Sec.# _____/_____/_____

Insurance Company _____ Group# _____

Insurance Co. Address _____ Ph.#_____

PATIENT NAME _____ DATE _____

Dental Information

PLEASE CIRCLE

Do your gums bleed when you brush?	YES NO
Are your teeth sensitive to heat or cold, pressure, or to sweets?	YES NO
Do you grind or clench your teeth?	YES NO
Have you had a bad reaction to Novacaine?	YES NO
Have you had any problems with previous dental work? Describe	YES NO
Does dental treatment make you nervous?	YES NO

Former Dentist _____ Last X-rays? _____

Medical Information

Medical doctor's name _____

Are you under a doctor's care now? Why?	YES NO
Have you been hospitalized during the past two years? Why?	YES NO
Are you taking any medications/pills/drugs? What?	YES NO
Are you taking or have taken Bisphosphonates for osteoporosis (ex. Boniva, Fosamax, Reclast)	YES NO
Are you allergic to any medications or substance? What?	YES NO
Are you allergic to latex?	YES NO
Are you pregnant? (women) If yes, what month?	YES NO

Do you have, or have you had any of the following?:

Heart Trouble	Yes No	Stroke	Yes No	Hepatitis	Yes No
High Blood Pressure	Yes No	Diabetes	Yes No	Thyroid Problems	Yes No
Low Blood Pressure	Yes No	Artificial Joints/Hips	Yes No	Glaucoma	Yes No
Heart Murmur	Yes No	Arthritis	Yes No	Mental Disorders	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Drug Addiction	Yes No
Congenital Heart Lesion	Yes No	Emphysema	Yes No	Cancer	Yes No
Heart Pacemaker/Valve	Yes No	Tuberculosis	Yes No	Chemotherapy/Radiation	Yes No
Heart Surgery	Yes No	Allergies	Yes No	Cold Sores/Fever Blisters	Yes No
Blood Disease	Yes No	Ulcers	Yes No	Venereal Disease	Yes No
Mitral Valve Prolapse	Yes No	Kidney Disorder	Yes No	HIV	Yes No
Anemia	Yes No	Lung Disease	Yes No	AIDS	Yes No
Fainting/Seizures	Yes No	Liver Disease	Yes No		

Have you ever had any other serious illness not circled above? ☐Yes ☐No

Describe in detail _____

Patient Signature _____ Date _____

Reviewed by: Doctor _____ Date _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	Changes in Health		PATIENT SIGNATURE	REVIEWED BY
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____
_____	_____	None ☐	_____	Dr. _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor make a thorough diagnosis of the patient's dental needs.

I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.

I understand that where appropriate, credit bureau reports may be obtained.

I understand that it is my responsibility to advise your office of any changes in the information obtained on the Health History/Information Form.

Patient_____Date_____Witness_____

Parent/Responsible Party_____Witness_____

FINANCIAL POLICY

ANTHONY B. CABEBE, D.D.S.
955 W. 7th St.
Oxnard, CA 93030
805-487-4977

- Payment for dental services is expected at the time dental care is provided. This office does NOT BILL the patient for services rendered.

- We accept the following methods of payment at the time of treatment:

    - Cash.
    - Check (personal, certified, money order). A fee of $25 will be assessed to your account for non-sufficient funds (NSF check).
    - Credit cards (Visa, Master Card, Discover, American Express).
    - Debit/ATM cards.
    - Care Credit, our personalized credit card company. Application available upon request.

- If you have dental insurance, we will process your claims as a courtesy for you. You must complete an Assignment of Benefits/Authorization for Signature on File form. This form must be maintained on an annual basis and is available through this office. You are responsible for the portion your insurance does not cover. You are also responsible for any applicable deductibles.

- After having a treatment consultation with Dr. Cabebe, you will receive a pre-treatment estimate of all costs involved. Total fees quoted may change depending on the progression of treatment. We will strive to ESTIMATE your share of the total cost so that you will be prepared to pay your portion on the actual date of service. Revisions to your account balance may occur once actual payment is received from your insurance company. ***Ultimately, the entire balance (BOTH PATIENT AND INSURANCE PORTIONS,) is the patient's responsibility.***

Signature of Patient/Parent	Date
Office Manager	Date
Anthony B. Cabebe, D.D.S.	Date

Authorization for Signature on File,
Authorization of Payment/Release of Information
And Financial Responsibility

I _____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that Anthony Cabebe, DDS has accepted the insurance company's verification of coverage and benefits in good faith and that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials, which I have incurred and authorized. I agree that any balance not paid by my insurance within 60 (sixty) days will be my responsibility to pay. I agree to furnish the office of Anthony Cabebe, DDS my insurance information and any necessary documents to expedite payment of my claims. To the extent permitted under applicable law, I hereby authorize release of any information relating to all claims for benefits submitted on my behalf. I hereby assign to Anthony Cabebe, DDS all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to me as if I had signed each benefit assignment of future claims. The "Signature on File" will be valid from this date and shall expire in one year.

Policy Name: _____ Policy #:_____

Patient's Signature: _____ Dated _____

If not signed by the patient, please indicate relationship:

[ ] Patient or guardian or minor patient (to the extent minor could not have consented to the care)

[ ] Guardian or conservator of patient

[ ] Beneficiary or personal representative of deceased patient

[ ] Spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

ANTHONY B. CABEBE, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

ANTHONY B. CABEBE, D.D.S.

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 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. 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 $0.25 for each page, $10.00 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.

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 or 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 contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: **Anthony B. Cabebe D.D. S., Attention: Caroline Acmor**

Telephone: **(805) 487-4977 Fax: (805)487-4548**

E-mail: **drcabebe@hotmail.com**

Address: **955 W. Seveth Street, Oxnard, CA 93030**