Welcome to Dr. Fossett's office

Thank you for choosing us to care for and treat all of your dental needs. Because your time is valuable, we have included some forms for you to fill out prior to your visit.

Included you will find a:

"Welcome/Contact Info" form

"Health History" form

"Restorative Choices" form

"Responsible Party/Cancellation Policy" form

"Privacy Practices" form

Please complete and sign all forms and bring with you on the day of your appointment. We appreciate your help and look forward to seeing you!

DR. DAVID FOSSETT & DR. DOUGLAS FOSSETT
8770 CUYAMACA ST. #1
SANTEE, CA 92071

619.448.8387
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FOSSETT D.D.S.

FAMILY, COSMETIC, & IMPLANT DENTISTRY

WELCOME TO DR. FOSSETT'S DENTAL OFFICE

We wish to thank you for placing your confidence in our office by allowing us to help you eliminate and control dental disease. In order for us to better serve you, please fill out this entire form.

PATIENTS NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP: _____ STATE: _____

HOME PH #: _____ CELL PH #: _____ WORK PH #: _____

DRIVER LIC #: _____ S.S. #: _____

EMPLOYER: _____ POSITION: _____

INSURANCE CO NAME: _____ GROUP #: _____

MARITAL STATUS: _____ NAME OF SPOUSE: _____

SPOUSE PH #: _____ SPOUSE INSURANCE CO: _____

CHILDREN AND THEIR AGE: _____

NAME, ADDRESS & PHONE # OF NEAREST RELATIVE NOT LIVING WITH YOU:

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: _____

WHAT IS YOUR PREFERED METHOD OF CONTACT?: ____ PHONE CALL ____ TEXT MESSAGE ____ EMAIL

WHAT DO YOU VALUE MOST IN YOUR DENTIST?:

_____

For your benefit a thorough examination, usually including dental x-rays, is necessary before intelligent and efficient analysis of your oral condition can be made. After thorough diagnosis, your dental issues can be discussed, treatment can be planned, and your investment in this health plan understood and arranged. ____ INITIAL

We like our patients to know what our office policy is with regard to insurance and the extension of credit. Payment is due the day treatment is rendered. We will be happy to bill your insurance company for you at no charge. All charges are the patients responsibility regardless of coverage. If special financial arrangements need to be made please talk with our financial coordinator. She will be happy to answer any of your questions concerning your insurance benefits or treatment. ____ INITIAL

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company/companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled. ____ INITIAL

SIGNATURE: _____

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Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐

Date Treatment began: _____

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, Specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments: _____

RESTORATIVE CHOICES FOR BACK TEETH

In our opinion, the most significant technological advance in the last decade in dentistry is the ability to chemically adhere a variety of restorative materials to your tooth. This revolutionized the way your damaged tooth can be restored and preserved. In your children, we can prevent much of the damage from happening in the first place with sealants.

In the past, choice was not such an issue when you had a dental problem. Now we have a number of options, and you need to be educated about what your choices are.

We are here to inform you and to help you intelligently decide which kind of materials to use in your teeth.

So, what's more <u>important</u> to you? Please check which applies in order of importance.

	VERY	MOST	SOMEWHAT	LEAST
Preservation of tooth structure ...				
How long it lasts ...				
Appearance ...				
Cost ...				
Metal Free...				

Signature _____ Date _____

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AUTHORIZATION FOR RESPONSIBLE PARTY AND CANCELLATION POLICY

We are committed to providing you and your family with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

PAYMENT: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, MasterCard, Visa, Discover or Care Credit.

PLEASE NOTE: If you elect to apply for third-party financing administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

DENTAL BENEFITS PLANS: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you and your employer and the plan. We are happy to help the, patients, parents and guardians of our patients with dental benefit plans to understand and maximize their coverage.

IF WE ARE A CONTRACTED PROVIDER WITH YOUR PLAN: You are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patients portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

IF WE ARE NOT A CONTRACTED PROVIDER WITH YOUR DENTAL BENEFIT PLAN: It is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If you plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

SCHEDULING OF APPOINTMENTS/CANCELLATION POLICY: We reserve time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require two (2) business days notice to reschedule and appointment. With less than two (2) business days notice, a fee of $50.00 per hour of missed appointment time may be assessed or a deposit required to reserve the appointment time again. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50.00 or a deposit may be required to reserve the appointment time again.

AUTHORIZATIONS: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I/child may need and have consented to during diagnosis and treatment .I have read the above and agree to the financial and scheduling terms. I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES/NO (Circle One). I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice

Signature of Responsible Party: _____ Date: _____

Dr. D. Fossett, DDS

I have received a copy of the Dental Materials Fact Sheet as required by law.

X_____

Acknowledgement of Receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Health Information

I hereby acknowledge that I received a copy of this dental practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I consent to this dental practice's use and disclosure of my/patient's protected health information to carry out treatment, payment activities, and healthcare operations.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient:_____