We are pleased you have selected us to provide dental care for you and your family.

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

Patient Information

Date ________ Patient's Name ____________________ (Last) (First) (Middle)

Address ____________________ (Street) (Unit#) (City) (State) (Zip)

Home Ph. # (____) ________ Work Ph. # (____) ________ Cell Ph. # (____) ________ Marital Status ________

Soc. Sec. # ______ - ______ - ______ Drivers Lic. # ____________ E-Mail: ____________

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name ____________

Name of nearest relative not living with you ____________ Relationship ____________

If patient is a full-time student, fill in school name ____________

School Address ____________ Ph. # (___) ________

Emergency Contact ____________ Ph. # (___) ________

Responsible Party Information

Name ____________________ (Last) (First) (Middle)

Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Relationship to Patient ____________

Residence ____________________ (Street) (Apt#) (City) (State) (Zip)

Mailing Address ____________________ (Street) (City) (State) (Zip)

How long at this address ________ Home Ph.# (___) ________ Work Ph.# (___) ________ Fax# (___) ________

Previous Address (if less than 3 years) ____________

Employer ____________ Occupation ____________ No. Years Employed ________

Employer Address ____________

Spouse's Name ____________

Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Work Ph.# (___) ________ Fax# (___) ________

Employer ____________ Occupation ____________ No. Years Employed ________

Employer Address ____________

Insurance Information

Insured's Name ____________ Insured's SS# ____________ Insured's DOB ________ ID# ________

Insurance Company ____________ Group # ________

Insurance Co. Address ____________ Ph. # (___) ________

Insured's Employer ____________ Ph. # (___) ________

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name ____________ Insured's SS# ____________ Insured's DOB ________ ID# ________

Insurance Company ____________ Group # ________

Insurance Co. Address ____________ Ph. # (___) ________

Insured's Employer ____________ Ph. # (___) ________

Dental Information

Do you gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit ____________ What was done at the time? ____________

Former Dentist Name ____________ City ____________

How would you describe your current dental problem? ____________

____

How do you feel about the appearance of your teeth? ____________

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the last two years? YES NO
3. Are you now taking any medication or drugs? YES NO
   If yes, please list: ____
4. A. Have you taken any medication or drugs during the last two years? YES NO
   B. Have you ever taken bisphosphonate medications for Osteoperosis or other bone loss related issues? YES NO
5. Have you been under the care of a medical doctor during the last two years? YES NO
   Physician's Name ____ Ph. # (___) ____
   Address ____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
   If yes, please list: ____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle) A B C		
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date ____		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than ten pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO
    If yes, please list: ____
15. Do you smoke? YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes ___ What month? ____ No ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? Yes ___ No ___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Guardian Signature ____ Date ____

Print Name ____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. 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.
3. 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 unless other arrangements have been made. 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.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient ____ Date ____ Witness ____

Print Name ____

Guardian/Responsible Party if minor ____ Relationship to Patient ____

Print Name ____ Date ____

OFFICE USE: Reviewed by Dr. ____ Date ____

Gilda C. Banta, D.D.S., Inc.

www.gildabantadds.com gildacbanta@gmail.com

4900 Edinger Ave. • Huntington Beach, CA 92649-2301 (714)846-4411

NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________ ______________________ ____ ______________________

Last First MI Preferred Name

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 15, 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 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.

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: Nancy Thompson (Office Manager)
Phone: (714) 846-4411
Fax: (714) 846-4061
Address: 4900 Edinger Ave.
Huntington Beach, California 92649-2301

AUTHORIZATION:

☐ I have read the information above regarding the Notice of Privacy Practices and acknowledge the receipt of copy of the Privacy Practices for this office.

☐ I have read the information above regarding the Notice of Privacy Practices and do not wish to receive a copy of the Privacy Practices for this office.

FOR MINORS ONLY: Name of Legal Guardian and relationship to patient:

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Response Date: __________