Torrance Dental Care

www.TorranceDentalCare.net
office@torrancedentalcare.net
3949 Artesia Blvd • Torrance, CA 90504
(310)878-0880

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: ___-__-____

Prev. Visit: _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

How did you hear about our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you could rate your smile from 1-10, what would it be?

_____

_____

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Please describe the primary reason for your visit (concerns):

_____

_____

How long has this been going on and what would you like done?

_____

_____

Would you like to improve your smile? ◯ Yes ◯ No

How?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Have you ever suffered from, or been told you may have any of the following?

- [ ] Had complications from past dental treatment
- [ ] Had trouble getting numb
- [ ] Had any reactions to local anesthetic
- [ ] Had/have braces, orthodontic treatment
- [ ] You experience dry mouth
- [ ] Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Have you ever whitened or bleached you teeth
- [ ] Have you experienced popping and/or clicking of your jaw joint
- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore or wake up frequently during the night or Stop breathing while sleeping
- [ ] Headaches or Migraines
- [ ] Malocclusion

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Your dental insurance is your responsibility...but we can help...Regardless of what we might calculate as your dental benefit in dollars,we must stress the fact that you, the patient are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render serender services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions pertaining to finances accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Financial Policy

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that patients are personally responsible for payment of all dental services.

Patient is financially responsible to pay fees for the treatment plan as well as dental, comprehensive and x-ray examinations whether or not the insurance company paid.

As a result of American Dental Association (ADA), California Dental Association (CDA) and The County Department of Public Health requiring to use additional Personal Protective Equipment (PPE) than before the Coronavirus pandemic (COVID-19) and the high demand and cost of PPE, Torrance Dental Care must charge an additional nominal fee to each patient in order to compensate and alleviate the extra cost.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy.**

Appointment Policy

Appointment Cancellation Policy:

We strive to render excellent dental care to you and our other patients. In an attempt to be consistent with this purpose, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Policy:

We understand that sometimes schedule adjustments are necessary. Therefore, we request that you provide our office with at least 24-hour notice for cancellation in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within 48 hours, this is considered a missed appointment. A fee of $50.00 will be charge to you; this fee cannot be billed to your insurance company and will be your direct responsibility. This fee also applies for last-minute cancellations. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Therefore, any missed appointments or last-minute cancellations with less than 48 hours' notice will result in a cancellation charge.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee is applicable. If you have any questions with regards to this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the appointment policy.**

Appointment Confirmation:

☐ I don't need a confirmation because I'm sure that I will keep my appointment. If I need to cancel, I will call before 48 hours of my appointment.

I only want:

☐ Phone Call ☐ Text ☐ E-mail

Non-Sufficient Funds (NSF), Charge-Back Credit Card Payment and Stop Payment Notice

Patient is responsible for fees that may be charged by financial institutions due to a charge-back credit card payment, or to stop-payment or insufficient-funds check.

Fees charged if patient does not have enough money in patient's account to cover the checks patient have written.

If your check is returned for insufficient funds, patient will be charged a $20.00 insufficient funds fee.

In the event of a returned check, Torrance Dental Care may charge patient an administration fee and require future payments to be in a form other than a personal check. Also, the account status of the patient may be change from active to inactive.

☐ **By checking this box, I acknowledge that I have read this statement and agree to the contents.**

X Ray Consent & Release

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the X Ray Consent/ X Ray Release.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Notice of Privacy Practices For Protected Health Information

We are required to provide this Notice to each patient beginning no laterr than the date of our first service delivery to the patient after April 14, 2003.We are required to make a good-faith attempt to obtain written acknowledgement of receipt of this Notice from each patient. We reserve the right to revise or amend this Notice of Privacy Practices.Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.Our practice will post a copy of our current Notice in our offices in visible location at all times, and you may request a copy of our most current Notice to take with you at any time. This Notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually indentifiable health information. Please review this Notice carefully.The privacy of your health information is important to us.

A. Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information, as required by applicable federal and state law.In conducting our business, we will create records regarding you and the treatment and services we provide to you.We are required by law to maintain the confidentiality of health information that identifies you.We also are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.By federal and state law,we must follow the terms of the Notice of Privacy Practices that we have in eefect at the time.

We realize that these laws are complicated,but we must provide you with the following important information:(1)how we may use and disclose your PHI,(2)your privacy rights in your PHI,and (3)our obligations concerning the use and disclose of your PHI.

B.We May Use and Disclose Your PHI in the Following Ways:

1.Treatment.Our practice may use or disclose your PHI to treat you.Additionally,we may disclose your PHI to others who may assist in your care,such as your spouse,children or parents.Finally,we may also disclose your PHI to other providers for purposes related to your treatment.

2.Payment.Our practice may use and disclose your PHI in order to bill/or collect payment for the services and items you may receive from us.For example,we may contact your health insurer to certify benefit elegibility and range of benefits.We may provide your insurer with details regarding your treatment to determine if your insurer will cover,or pay for,your treatment.We also may use and disclose your PHI to obtain payments from third parties that may be responsible for such costs,such as family members. In addition,we may use your PHI to bill you directly for services and items.We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

3.Healthcare operations.Our practice may use and disclose your PHI in order to operate our business.We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.Healthcare operations include quality assessment and improvement activities,reviewing the competence or qualifications of healthcare professions,evaluating practitioner and provider performance,conducting training programs,accreditation,certification,licensing or credentialing activities.

4.Appointment reminders.Our practice may use and disclose your PHI to contact you and provide you with appointment reminders (such as voicemail messages,postcards and/or letters.)

5.Treatment options.Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6.Health-related benefits and services.Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of information to family/friends.Our practice may release your PHI to a friend,family member or other person to the extent necessary to help with your healthcare or payment for your healthcare,but only if you agree that we may do so.

Release of information to persons involved in care.Our practice may use or disclose your PHI 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 disclose of your PHI,we will provide you with an opportunity to object to such uses or disclosures.In the event of your incapacity or emergency situations,we will disclose PHI based on a determination using our professional judgment,disclosing only health information that is directly relevant to the person's invlovement in your healthcare.We will also use our experience and professional judgment 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.Our practice will not use your health information for marketing communications without your written authorization.

Disclosures required by law.Our practice will use and disclose your PHI when we are required to do so by federal,state or local law.

C.Use and Disclosure of Your PHI in Certain Special Circumstances:

1.Public health risks.Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

-Maintaining vital records,such as births and deaths,

-Reporting child abuse,neglect,or reactions to drugs or problems with products or devices,

-Preventing or controlling disease,injury or disability,

-Notifying a person regarding potential exposure to a communicable disease,or regarding a potential risk for spreading or contracting a disease or condition,or if a product or device they may be using has been recalled,

-Notifying appropiate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence);however,we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,

-Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health oversight activities.Our practice may disclose your PHI to a health oversight agency for activities authorized by law.Oversight activities can include,for example,investigations,inspections,audits,surveys,licensure and disciplinary actions;civil,administrative and criminal procedures or actions;or other activities necessary for the

government to monitor government programs,compliance with civil rights laws and the healthcare systems in general.

Lawsuits and similar proceedings.Our practice may use and disclose your PHI in response to a court or administrative order,if you are invloved in a lawsuit or similar proceedings.Our practice must first make an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4.Law enforcement.Our practice may release PHI if asked to do so by a law enforcement offical:

-Regarding a crime victim in certain situations,if we are unable to obtain the person's agreement,

-Concerning a death we believe has resulted from criminal conduct,

-In response to a warrant,summons,court order,subpoena or similar legal process,

-To identify/locate a suspect,material witness,fugitive or missing person,

-In an emergency,to report a crime (including the location or victim(s) of the crime,or the description,identiity or location of the perpetrator).

5.National Security.Under certain circumstances,our practice may disclose to military authorities the PHI of Armed Forces personnel.We may disclose to authorized federal officials PHI required for lawful intelligence,counterintelligence,and other national security activities.Also under certain circumstances,our practice may disclose PHI to a correctional institution or law enforcement official having lawful custody of an inmate or patient.

6.Deceased patients.Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.If necessary,we also may release information in order for funeral directors to perform their jobs.

D.Your Rights Regarding Your PHI:

1.Confidential communications.You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.You must make this request in writting and it must specify the alternative manner or location,and provide a satisfactory explanation how payment will be handled under the alternative manner or location that you request.Our practice will accommodate reasonable requests.

2.Requesting restrictions.You have the right to request additional restrictions in our use or disclosure of your PHI.We are not required to agree to your request;however,if we do agree,we will abide by our agreement,except when otherwise required by law,in emergencies or when the information is necessary to treat you.You must make your request in writing.Your request must describe in a clear and concise fashion:

-The information you wish restricted,

-Whether you are requesting to limit our practice's use,disclosure or both,

-To whom you want the limits to apply.

3.Inspection and copies.You have the right to inspect or get copies of your PHI,with limited exceptions.You may request that we provide copies in a format other than photocopies.Our practice will use the format you request,unless we cannot practicably do so.You must submit your request in writing in order to inspect and/or obtain a copy of your PHI.Our practice may charge a fee for the costs of copying,mailing,labor and supplies associated with your request.Our practice may deny your request to inspect and/or copy in certain limited circumstances;however,you may request a review of our denial.Another licensed healthcare professional chosen by us will conduct reviews.

4.Amendment.You may ask us to amend your PHI if you believe it is incorrect or incomplete.Your request for an amendment must be made in writing and must provide us with a reason that supports your request for amendment.Our practice may deny your request under certain circumstances.

5.Accounting of disclosures.Our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment,payment or operations.Use of your PHI as part of the routine patient care in our practice is not required to be documented.In order to obtain an "accounting of disclosures," you must submit your request in writing.All requests for an "accounting of disclosures" must state a time period,which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14,2003.The first list you request within a 12-month period is free of charge,but our practice may charge you for additional lists within the same

12-month period.Our practice will notify you of the costs invloved with additional requests,and you may withdraw your request before you incur any costs.

Right to a paper copy of this Notice.You are entitled to receive a paper copy of our Notice of privacy practices.You may ask us to give you a copy of this Notice at any time.

Right to provide an authorization for other uses and disclosures.Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing.After you revoke your authorization,we will no longer use or disclose your PHI for the reasons described in the authorization.Please note: we are required to retain records of your care.

E.Questions and Complaints.

1.Questions.Please contact the Contact Officer listed below should you have any additional questions regarding the Notice or need additional information regarding our privacy practices.

Complaints/Requests.If you believe your privacy rights have been violated,if you disagree with a decision made about access to your PHI,in response to a request you made to amend or restrict the use or disclosure of your PHI,or to have us communicate with you in alternative manners or alternative locations,you may file a complaint or request with our practice.You can do so by contacting the Contact Officer listed below.You may also submit your complaint to the U.S. Department of Health and Human Services.(Our practice will provide you with their address upon request.)All complaints must be submitted in writing.We support the right to the privacy of your health information.You will not be penalized should you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Dr.Naomi Osada D.D.S

Telephone: (310)878-0880 Fax: (310)220-0776

Address: 3949 Artesia Blvd. Torrance, CA 90504

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Notice of Privacy Practices.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Response Date: _____