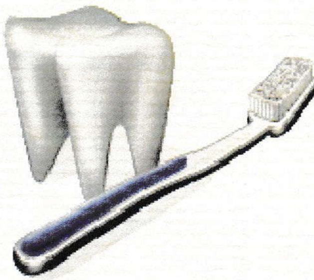
Welcome



Dr. Richard Janis DDS
www.dr-richardjanis.com

Patient Information:

Date: ______________________________

Name: _________________________ **Preferred Name:** _______________ **Birthdate:** ____________ **Home Phone:** _____________
Address: ___________________________________ **City:** ________________________ **State:** ___________ **Zip:** _______________
E-mail: _____________________________________ **Cell Phone:** _______________ **Work Phone:** __________________________
Social Security # _____________________________

Check Appropriate Box: □ **Minor** □ **Married** □ **Domestic Partner** □ **Divorced** □ **Widowed** □ **Single**

If Student, Name of School: ____________________ **City:** _________________ **State:** _______ □ **Full Time** □ **Part Time**

Employer: ____________________ **Employer's Address** ______________________ **Occupation**______________________________

Emergency Contact's Name and Number:____

Whom May We Thank For Referring You:? Name: _________________ **Yahoo** □ **Google** □ **Mail** □ **Other:**___________________

Responsible Party (If Different Than Above):

Name: ______________________________ **Birthdate:** _______________ **Home Phone:** ___________________________________
Address: ____________________________ **City:** ________________________ **State:** ___________ **Zip:** _____________________
E-mail: ______________________________ **Cell Phone:** _____________________ **Work Phone:** ___________________________
Relationship to Patient: _____________________________

Insurance Information:

Name of Insured: _________________________ **Relationship to Patient:** ______________________ **Birthdate:** _________________
Social Security Number: __________________ **Insurance ID Number:** ________________________ **Employer:** _________________
Insurance Company Name: _______________________ **Insurance Company Phone Number:** ________________________________

Do You Have Any Additional Insurance? □ **Yes** □ **No If Yes, Complete The Following:**

Name of Insured: _________________________ **Relationship to Patient:** _______________________ **Birthdate:** ________________
Social Security Number: __________________ **Insurance ID Number:** ________________________ **Employer:** _________________
Insurance Company Name: _________________________ **Insurance Company Phone Number:** ______________________________

Office Policy:

Payment in full is required at the time of service unless other arrangements have been made. For patients with insurance, we will require your copayment and we will bill your insurance company for you. Unpaid balances will be billed to your credit card on file. Appointment time is reserved only for you. If you need to change your appointment, you must notify us 48 hours in advance. A based on appointment time reserved will be charged for late cancelations or missed appointments.

I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment in full on date of services rendered. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges.

____

Signature **Date**

Physician: ______________________ Office Phone: ______________ D   f Last Exam: ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes explain ______________________	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ________	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to:

	Yes	No		Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐	Latex Rubber	☐	☐
Penicillin or any other Antibiotics	☐	☐	Sulfa Drugs	☐	☐
Barbiturates	☐	☐	Sedatives	☐	☐
Iodine	☐	☐	Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc)	☐	☐	Other (please list)	☐	☐

	Yes	No
10. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks?	☐	☐
11. Women only:		
a) Are you pregnant or think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart murmur	☐	☐	Stroke	☐	☐
Swollen ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low blood pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint replacement/implant	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV infection	☐	☐	Stomach Troubles/Ulcers	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	STD's	☐	☐	Other ____________	☐	☐

Patient Dental History

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

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

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

Would you like to improve your smile? Yes No How?______________________________

Name of Previous Dentist and Location______________________________ Date of Last Exam______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain in any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any prolonged bleeding, following extractions?	☐	☐
12. Have you ever had any difficult extractions in the past?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? if yes, date of placement______________	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐

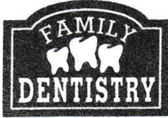
Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. X______________________________

Dentist & Hygienist Comments:

Date & Comments: ______________________ Date & Comments: ______________________

Date & Comments: ______________________ Date & Comments: ______________________



Richard Janis DDS

OUR FINANCING OPTIONS

Thank you for selecting our office to serve your dental needs. We believe it is important not only to provide the highest quality dental care, but to make this type of care affordable for our patients. We have made arrangements for our patients, which allow payment to be convenient and flexible. For your convenience, we accept cash, check,Visa, MasterCard, Discover, or Care Credit credit cards.

We do not want finances to be an issue for our patients and everyone benefits when financial policy arrangements are understood, please review the plans listed below. Give some thought to which one may serve you best in meeting your needs. Our financial coordinator will consult with you on specific details to make your obligation comfortable for you.

For Treatment under $300.00 we offer:

Cash, Check or Visa/MasterCard/Discover for full treatment.
Cash, Check or Visa/MasterCard/Discover for patient estimated co-pay.*
(With verification of insurance benefits)** ***Please note insurance information below.

For Treatment over $300.00 we offer:

1. **Discount when paying in full at the time of your treatment with cash, check, credit card.**
**Not applicable for insurance contracts.*
2. **Pay 50% at the time of treatment** and the balance at the completion of your treatment.
3. **Estimated payment at each visit with cash, check, or credit card.**
**(With verification of insurance benefits) Please note insurance information below.*
4. **6 or 12 month Interest-free payment plan** through Care Credit.

**** Note to patients with insurance***

We are happy to process any insurance claim as a service to you at no charge. Please keep in mind that any insurance payment estimate that we provide for you is **only an estimate**, we can not predict what the insurance company will do, and you are **fully responsible** for all fees in their entirety. We are proud that our fees reflect the time that the doctor spends with each patient as well as the overall quality of care and service that we provide in our practice. Our fees are based upon Usual, Customary & Reasonable Fees, and are often above insurance allowances.

We have noticed that in recent year's insurance benefit plans have lowered their benefits, no longer pay for necessary treatment, deceased their table of allowances, added waiting periods on most procedures, increased deductibles, and yet have kept the yearly maximums the same as 20 years ago. You may wish to complain to your company's benefits representative should your benefits be less than you expected.

We will hold your account open for 60 days after treatment is completed to allow your insurance company to pay us. At the end of 60 days you will be responsible to pay the balance of your account in full.

1949 Parkside Drive, Concord, California 94519 • Phone (925) 689-4020 • Fax (925) 689-7227

Richard Janis, D.D.S. • (925) 689-4020

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):______________________________

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

____

Patient Signature

Date ______ / ______ / ______

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

#FM-0304 • Printed in U.S.A.
©SmartPractice™ 1-800-522-0800