TIME 11:34 AM DATE 1/10/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

ROCKSTAR
FAMILY DENTAL

3071 Stanford Ranch Rd, Suite C3
Rocklin, CA 95765

Tel: (916) 771-7873
Fax: (916) 435-8234

Patient Consent Form: Use and Disclosure of Health Information Protected Under HIPPA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent disclosures have been made in reliance upon my prior consent.

I hereby consent that photographs may be taken during my treatment to be used in a manner for medical programs developed on behalf of Rockstar Family Dental. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chart.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Initial_____

I have been given the Dental Materials Fact Sheet as required by law dated May 2004.

Initial_____

In the event that I am unable to be reached for appointment confirmations or to discuss my personal information or dental

treatment plan, I authorize _____to discuss these matters with Rockstar Family Dental.

Initial_____

Patient Name:_____Date:_____

Patient Signature or Legal Guardian:_____

Time 11:36 AM | Gina L Salatino DMD,FAGD | Date 1/10/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

ROCKSTAR
FAMILY DENTAL

3071 Stanford Ranch Rd, Suite C3
Rocklin, CA 95765

Tel: (916) 771-7873
Fax: (916) 435-8234

CANCELLATIONS & FAILED APPOINTMENTS POLICY

If you are unable to keep an appointment that has been reserved especially for you, we request that you provide us with a

- ONE WEEK ADVANCED NOTICE FOR SURGICAL PROCEDURES
- and a 48-HOUR ADVANCED COURTESY NOTICE FOR ALL OTHER APPOINTMENTS.

- Otherwise a fee of **$75 per hour** of the appointment may occur. **If you arrive later than 15 minutes into your scheduled appointment time we will be unable to see you and will result in a **$75 per hour late fee.**

Please note that you must speak with a live operator to make any cancelations and changes to your appointment. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize that emergencies do occur and we will be flexible under those circumstances.

Patient Name: Signature Date

ROCKSTAR
FAMILY DENTAL

3071 Stanford Ranch Rd, Suite C3
Rocklin, CA 95765

Tel: (916) 771-7873
Fax: (916) 435-8234

Office Policies for Rockstar Family Dental

EXPECTED PAYMENT
To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an ***estimate*** for services will be prepared in advance of your appointment/s to ensure you the opportunity to plan for your dental care. We believe whether you pay privately or have dental insurance to assist you, everyone deserves the care they need and want.

DENTAL INSURANCE
We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. Please understand that by signing below you are authorizing us to submit insurance claims, to submit any information requested by your insurance carrier, and accept payment on your behalf. We request you familiarize yourself with your insurance benefits and provide us with the correct information to assist you with the submittal of your claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received within 90 days. Please realize that your insurance is a contract between you, your employer, and the insurance company. Therefore, *we cannot guarantee coverage* and your assistance may be requested. Not all services are covered benefits in all contracts; therefore, *you are ultimately responsible* for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your insurance benefits, deductibles, limitations, or maximums.

PAYMENT OPTIONS
For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and a confident smile. Please identify which form of payment is most convenient for you at the time of service. We accept the following forms of payment: Cash/check, Cashier's Check, Visa/MasterCard, American Express, and Care Credit (Third party medical credit plan. See plan brochure for details)
(We offer a 10% courtesy discount to patients who pay for their treatment in full with cash prior to completion of care*)
Please note: A fee of $30 will be charged for any cancelled or returned checks

PAST DUE BALANCES
Payment of any past due balance is required to be paid in full before incurring new charges. These include the following: balances owing from a prior visit where insurance is not pending, or an insurance payment that has not been received within 90 days. Balances over 90-days may be subject to a rebilling fee.
Please note: any account that has been sent to collections, must contact the collection agency directly.

CANCELLATIONS/ FAILED APPOINTMENTS
If you are unable to keep an appointment that has been reserved especially for you, we request that you provide us with a ONE WEEK ADVANCED NOTICE FOR SURGICAL PROCEDURES and a 48-HOUR ADVANCED NOTICE FOR ALL OTHER APPOINTMENTS. Otherwise a fee of $75 per hour of the appointment may occur. Please note that you must speak with a live operator to make any cancelations and changes to your appointment. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize that emergencies do occur, and we will be flexible under those circumstances.

SURGERY RESERVATIONS
Please make every effort to keep your surgery appointment as the dental treatment prescribed especially for you, does not change due to postponement of your surgery, resulting in deteriorating dental health. A deposit will be collected for all surgical procedure prior to scheduling the appointment date. A refund may be eligible only if canceled with a minimum of *ONE WEEK* advanced notice.

CELL PHONES
We ask that cell phones be turned off at ALL times while in our office as it interferes with our ability to care for you. If being available for an emergency during your reserved appointment is necessary, please leave our office telephone number so you can be reached. Should an unfortunate emergency arise we would be happy to notify you in the treatment area immediately.

INFORMATION CHANGES
To ensure your records are current, and to assist us in billing your insurance carrier, please notify us of any changes related to medical history, telephone number(s), address, employer or insurance information as they occur.

My Signature indicates that I understand the policies, and any questions I have in regard to the office policies, have been answered to my satisfaction.

Signature of Responsible Party or Patient **Patient Name** **Date**

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

Signature of Staff Member or Doctor **Date**

*not valid with any other offer, discount or promotion

ROCKSTAR
FAMILY DENTAL

3071 Stanford Ranch Rd, Suite C3
Rocklin, CA 95765

Tel: (916) 771-7873
Fax: (916) 435-8234

Patient Introduction to Laser Bacterial Reduction

We are constantly learning and striving to advance the standard of patient care in our office. As such we have recently added a new procedure to your routine cleaning care to help fight periodontal disease.

Periodontal disease affects approximately 80% of adults and is a growing epidemic in our society. Understanding of this disease has increased greatly over the last few years. We now know that Periodontal Disease is a bacterial infection in the pockets around teeth. As such, we now not only treat Perio with removal of mechanical irritants and diseased tissue (your normal cleaning) but are also addressing the underlying infection that causes it. With that thought in mind we recommend that all of our patients have their teeth decontaminated prior to cleaning appointments for three major reasons.

1. **To reduce or eliminate bacteremia's.** During the normal cleaning process most patients will have some areas that may bleed, this allows bacteria that are present in all of our mouths to flood into the bloodstream and sometimes settle in the weakened areas of our body such as a damaged heart valve. We pre-medicate those patients that we know have a heart condition or artificial joints with antibiotics so that these bacteria can't cause harm to these areas. Latest research shows that these oral pathogens have now been linked to a number of other diseases such as cardiovascular disease, rheumatoid arthritis, low birth weight babies, diabetes etc. Needless to say anything that we can do to reduce or eliminate these bacteremia's is a positive for our patients.

2. **To prevent cross contamination** of infections in one area of your mouth to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to others.

3. **To kill periodontal disease bacteria** and stop their infections before they cause physical destruction or loss of attachment around your teeth.

The laser decontamination process is painless and normally takes about 5-10 minutes. We **highly** recommend that you take advantage of this service as part of your routine cleaning.

Laser decontamination is **$36** and is **NOT** covered by insurance. Unfortunately insurance coverage is almost always behind the leading edge in high tech health care.

Please ask the hygienist or doctor if you have any questions regarding this treatment.

By initially this page acknowledges that have been informed regarding what the Laser Bacterial Reduction therapy is, and that it is not covered by insurances.

_____ Initials

_____ Date: