ARTISAN
DENTAL GROUP

Welcome to Artisan Dental Group!! This letter is to acquaint our new patients with our general office policies to help avoid any misunderstandings. Our responsibilities are to you as our patient. We practice preventive dentistry and stress the importance of regular care to help you in your goal to achieve and maintain excellent dental health.

Insurance Patients: If you have dental insurance, it is your responsibility to bring a completed and signed form with you. We will file insurance claims as a courtesy to our patient. Remember that your insurance contract is between you and your insurer. It is your responsibility to be aware of insurance available for each treatment, any specific clauses stated in your policy, and deductibles and waiting periods. Insured patients should be prepared to pay their co-pay and/or deductible at time of service. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance will be due upon receipt of your statement. It is also your responsibility to make sure that we are a listed provider with your insurance company.

Patients with no Insurance: Patients with no insurance are required to pay for their treatment in full at the time of service, unless other prior arrangements are made.

Payment: We honor Visa, MasterCard, Cash and Personal Checks with proper identification. Checks written with insufficient amount will have accounts billed $50.00 for each bad check. Statements will be sent out on a monthly basis.

Delinquent Accounts: Any fees, such as Attorney's fees, collection agency fees and court costs incurred as a result of overdue accounts will be the patient's complete financial responsibility.

We try to see our patients as promptly as possible. However, there are times when emergencies and/or surgeries may arise causing unavoidable delays.

We ask that our patients please give us at least 48 hour notice when canceling an appointment. These times are reserved for you. Failure to give notice will result in a broken appointment charge.

Our goal is to make your appointment as comfortable, safe and pleasant as possible. If you should have any questions or suggestions, please feel free to discuss them with our doctor and staff.

By signing on the line below I am stating that I have read or have had it read to me and I understand my responsibilities listed in the above policies.

_____ _____

Patient or Guardian's Signature Date

ARTISAN
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Our Commitment to You

Commitment to treat:
Our office believes that all treatment should be completed. We will deliver the best care that we are capable of delivering and ask that the patient care for their dental health on a daily basis. Incomplete treatment leads to unnecessary problems, complications and advanced disease, which may add cost and breakdown in communication between patient and doctor. We believe that patients want as little dentistry done in their lifetime.

Commitment to Appointment:
Our office will reserve for the patient and give the patient the utmost attention and care. An appointment is a bond of trust that our team will be here to serve the patient and will be on time and prepared for their appointment.

Commitment to Financial Consideration:
We believe that we have a responsibility to use our best professional care, skills and judgment in assisting the patient to achieve their dental health goals. In return for our commitment to our patients we ask that they accept their financial responsibilities.

We look forward to partnering with you.

Dr. Callejo and Team

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Patient Information (confidential)

Patient ID #_____
SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Work Phone_____ Cell Phone _____

Check Appropriate Boxes: □Male □Female □Minor □ Single □ Married □Divorced □ Widowed □ Separated

If Student, Name of School/College_____ City _____ □part-time □full-time

Patient's or Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Guardian's Name _____ Employer _____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

is this person currently patient in our office? □ Yes □ No

Name of Person Responsible for this account _____ Relation to Patient _____

Address_____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#_____

Dental Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____ Email _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional insurance? □ *Yes* □ *No* *(if yes, complete the following below)*

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____ Email _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

ARTISAN DENTAL GROUP

Physician _____
Office Phone _____
Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation/serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Are you under the care of a psychiatrist?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Heart Attack	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Frequently Tired	☐	☐	Hay Fever/Allergies	☐	☐
Swollen Ankles	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Fainting/Seizures	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Epilepsy/Convulsions	☐	☐	Joint Replacement/Implant	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Hepatitis/Jaundice	☐	☐	Heart Trouble	☐	☐
Sexually Transmitted (STD)	☐	☐	Diabetes	☐	☐	Respiratory Problems	☐	☐
Kidney Disease	☐	☐	Stomach Troubles/Ulcers	☐	☐	Thyroid Problem	☐	☐
AIDS or HIV Infection	☐	☐	Osteoporosis	☐	☐	Heart Disease	☐	☐
Obstructive Sleep Apnea	☐	☐	Chest Pains/Angina	☐	☐	Bleeding Disorder	☐	☐
Cardiac Arrhythmias/			Mitral Valve Prolapse/			Other _____	☐	☐
Irregular Heart Rhythm	☐	☐	Leaky Heart Valve	☐	☐	Other _____	☐	☐

	YES	NO
10. Have you ever had difficulties with general anesthesia or sedation?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex (rubber)	☐	☐
Other (please list) _____	☐	☐
12. Do you have a persistent cough/throat clearing not associated with a known illness (lasting more then 3 weeks)	☐	☐
13. Women only: a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

OFFICE USE ONLY

BP _____ Pulse_____ O2Sat_____ EKG _____

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Patient Dental History

Name of Previous Dentist _____

Office Phone or 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 to 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?		
a. Clicking?	☐	☐
b. Pain (joint, ear or side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. 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 difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had an orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, what was the date of placement? _____		
15. Do you like your smile?	☐	☐

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services preformed without previous financial arrangements, must be paid for in cash at the time services are preformed.

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 patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance companies. I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the doctor, I agree to pay therefore the value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____

Signature of patient/guardian Date Relationship to patient

_____ _____ _____

Signature of responsible party/guarantor Date Relationship to patient

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

This undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

_____ _____

Please PRINT name of PATIENT | Please SIGN for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

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Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY CHILD'S HEALTH BE CONVEYED VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration form these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Employee, I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment □
- I could not communicate with the patient □
- The patient refused to sign □
- The patient was unable to sign because □
- Other (please describe) □

_____

Signature of Employee