SKYLINE DENTAL
GENERAL and COSMETIC DENTISTRY

20747 Amar Rd, Suite 5
Walnut, CA 91789
Tel: (909) 595-1800

www.skyline2th.com
Skyline.dental@gmail.com
Fax: (909)594-8915

DATE _____

PATIENT INFORMATION
(PLEASE PRINT)

NAME _____ BIRTH DATE _____ SOCIAL SECURITY #: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX(ES): ☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ MINOR

EMAIL: _____ CELL PHONE ( )_____ OK to send text reminder? ☐ Yes ☐ No

HOME PHONE ( )_____ WORK PHONE ( )_____ ext. _____

EMPLOYER _____ EMPLOYER PHONE ( )_____ ext. _____

SPOUSE OR PARENTS' NAME: _____ PHONE ( )_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT: _____ RELATIONSHIP_____ PHONE ( )_____

DENTAL HISTORY
Reason for today's visit: _____

Former Dentist:_____ Date of Last x-ray diagnosis: _____

Date of last dental visit: _____ Work done (*circle*): Check up Cleaning Fillings Root Canal Other:_____

How often do you brush daily _____ Floss _____ Do you have a habit of 6 month check-ups ☐ Yes ☐ No

(WOMEN) Are you: PREGNANT? ☐ Yes ☐ No NURSING? ☐ Yes ☐ No TAKING BIRTH CONTROL PILLS? ☐ Yes ☐ No

CHECK (✓) **YES** or **NO** IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

Y	N		Y	N		Y	N	
☐	☐	*Bad Breath*	☐	☐	*Grinding teeth*	☐	☐	*Sensitivity to hot*
☐	☐	*Bleeding Gums*	☐	☐	*Loose or broken teeth*	☐	☐	*Sensitivity to sweets/sugar*
☐	☐	*Clicking or popping jaw*	☐	☐	*Periodontal treatment*	☐	☐	*Sensitivity when biting*
☐	☐	*Food Collection between teeth*	☐	☐	*Sensitivity to cold*	☐	☐	*Sores or growths in your mouth*

(Please fill out the back page also)

MEDICAL HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST VISIT_____

HAVE YOU HAD ANY ILLNESSES? ☐Yes ☐No IF YES, DESCRIBE _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐Yes ☐No IF YES, GIVE APPROXIMATE DATE _____

Have you ever taken any of the group of drugs collectively referred to as **"fen-phen?"** These include combinations of Ionimin, Apidex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dextenfluramine) ☐Yes ☐No

Check (✓) **YES** or **NO** if you have had problems with any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	*Anemia*	☐	☐	*Cortisone Treatments*	☐	☐	*Hepatitis*	☐	☐	*Scarlet Fever*
☐	☐	*Arthritis, Rheumatism*	☐	☐	*Cough, Persistent*	☐	☐	*High Blood Pressure*	☐	☐	*Shortness of Breath*
☐	☐	*Artificial Heart Valves*	☐	☐	*Cough up blood*	☐	☐	*HIV/AIDS*	☐	☐	*Skin Rash*
☐	☐	*Artificial Joints*	☐	☐	*Diabetes*	☐	☐	*Jaw Pain*	☐	☐	*Stroke*
☐	☐	*Asthma*	☐	☐	*Epilepsy*	☐	☐	*Kidney Disease*	☐	☐	*Swollen feet/Ankles*
☐	☐	*Back Problems*	☐	☐	*Fainting*	☐	☐	*Liver Disease*	☐	☐	*Thyroid problems*
☐	☐	*Blood Disease*	☐	☐	*Glaucoma*	☐	☐	*Mitral Valve Prolapse*	☐	☐	*Tobacco Habit*
☐	☐	*Cancer*	☐	☐	*Headaches*	☐	☐	*Pacemaker*	☐	☐	*Tonsillitis*
☐	☐	*Chemical Dependency*	☐	☐	*Heart Murmur*	☐	☐	*Radiation Treatment*	☐	☐	*Tuberculosis*
☐	☐	*Chemotherapy*	☐	☐	*Heart Problems*	☐	☐	*Respiratory Disease*	☐	☐	*Ulcer*
☐	☐	*Circulatory Problems*	☐	☐	*Hemophilia*	☐	☐	*Rheumatic Fever*	☐	☐	*Venereal Disease*

ALLERGIES:

☐ASPIRIN ☐BARBITUATES (sleeping pills) ☐CODEINE ☐PENICILLIN ☐SULFA ☐LATEX ☐OTHER_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Skyline Dental may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient, Parent or Legal Guardian: _____ Date:_____

Co-payments are due in full at time of treatment unless prior arrangements have been approved

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO 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, or to family and friends you approve.
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 actives.
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. You also have the right to request restrictions and disclosure of PHI (Personal Health Information), or alternative means of communication ensure privacy.
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 required to do so by law or national security activities.
Abuse or Neglect: We may use or disclose your health information to appropriate authorities when we suspect abuse or neglect.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminder (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. If you a request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you. **(Amendment):** You have the right to request that we amend your health information.

QUESTIONS AND COMPLANTS: 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 right, 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 use communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on the first page of the New Patient Forms. 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 health information.
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

_____ _____
Print Patient's Name ***Date***

I,_____, have received a copy of this office's NOTICE OF PRIVACY as required by federal law.
(Signature of patient or parent or Legal Guardian)

I,_____, consent to the use and disclosure of my personal health information by your office
(Signature of patient or parent or Legal Guardian)

during Treatment, Billing/Payment and Healthcare options as outlines in the Notice of Privacy Practices.

(Please fill out the back page also)

FINANCIAL AGREEMENT

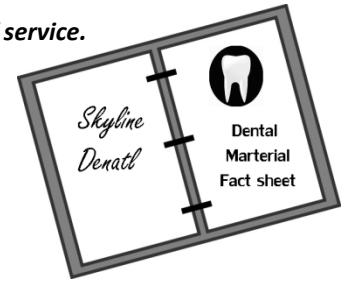
Thank you for choosing Skyline Dental. It is our goal to provide the finest care possible. This information will explain how we will help you take care of your financial needs.

Payment Options Available:
MasterCard, Visa, Discover, Capital One, Chase Health Advance Financing Option, and Cash. Sorry **NO CHECKS.**

Insurance:
As a courtesy, we will bill your insurance company for covered charges. In order to do this, you will need to provide us with the necessary accurate information. **Remember, your policy is a contract between you and your insurance.** You are responsible for all charges incurred. We expect insurance payment within 45 days from the date of service. If your insurance has not paid, and the account becomes 60 days old, the account may become a cash account and be payable at the time. We reserve the right to run a credit report, should the account remind unpaid.

I HEREBY GUARANTEE PAYMENT OF ALL CHARGES INCURRED FOR THE ACCOUNT OF THE ABOVE MENTIONED. I REALIZE THAT INSURANCE MAY NOT COVER THE AMOUNT CHARGED AND THAT I WILL BE RESPONSIBLE FOR THE BALANCE. I UNDERSTAND THAT BALANCES NOT PAID IN A TIMELY MANNER ARE SUBJECT TO ADDITIONAL FEES AND OR COLLECTION PROCEDURES. I AUTHORIZE SKYLINE DENTAL TO AFFIX MY NAME TO ANY AND ALL INSURANCE CLAIMS OR DOCUMENTS, AND AUTHORIZE PAYMENT OF DENTAL BENEFITS DIRECTLY TO SKYLINE DENTAL. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THE CLAIM.

If there is no insurance coverage, I understand that I am responsible for all charges incurred at the time of service.



_____ _____
Signature Date

I, _____ have read the **Dental Materials Fact Sheet** as required by Law.

_____ _____
Signature Date

24-Hour Cancellation Policy

At Skyline Dental, we are always aiming to provide our patients with the highest quality of service as we pride ourselves on our exceptional team. Please be aware that by making an appointment with our treating doctors and assistants, as well as the treatment coordinator, you are agreeing to abide by the billing policies of our practice. In the case of cancellation within 24 hours of your scheduled appointment, **there will be a cancellation fee of $50 billed to you personally**. This fee must be paid off before additional appointments can be scheduled. The cancellation fee applies to each patient individually and is not inclusive for family cancellations. We hope you understand that when you cancel your appointment less than 24 hours of your scheduled appointment, we not only lose your business, but also the potential business of other patients who may have taken your scheduled appointment time.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Skyline Dental as described above. Our office manager will be happy to answer any further questions regarding this policy.

Thank you for your understanding and cooperation.

Acknowledgement of Policy: _____ Date:_____

Relationship to Patient (If someone other than patient): _____