

TMJ & Sleep Apnea Center

Patient Registration

Platinum Dental, Inc.

Please complete the following confidential information.

Patient's Name: _____

Mr. ____ Mrs. ____ Ms. ____ Miss ____ Dr. ____ Other ____

Name you prefer to be address by: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Length of Employment: ____ Mos./ Yrs. Occupation: _____

If patient is a child, Parent's Name: _____

School's Name: _____

Grade: _____ Full Time Student: Yes ____ No ____

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

E-mail: _____

Social Security #: _____ - _____ - _____

Birth Date: ____ / ____ / ____ Male ____ Female ____

Married ____ Single ____ Divorced ____ Other ____

Person to contact in case of an emergency:

Name: _____ Relation: _____

Phone: () _____

Alternate Phone: () _____

Name of Person Responsible for this Account: _____

Please complete the following information in full if you would like us to assist you with your insurance claims.

Primary Dental Insurance Company: _____ Phone () _____

Group/Policy #: _____ ID #: _____ Subscriber is: Self ____ Spouse ____

Secondary Dental Insurance Company: _____ Phone () _____

Group/Policy #: _____ ID#: _____ Subscriber is: Self ____ Spouse ____

Medical Insurance Company: _____ Phone () _____

Group/Policy #: _____ ID#: _____ Subscriber is: Self ____ Spouse ____

If the insurance coverage is through your spouse, please provide us with Spouse's Name: _____

Spouse's Employer Name: _____ Phone: () _____ ext.: _____

Spouse's Employer Address: _____

Spouse's Social Security Number: _____ Spouse's Birth Date: _____

How did you hear about our office? (Please circle): Banner Flyer Internet Website Yellow Pages Patient Doctor Other

Whom may we thank for referring you to us? _____

I hereby authorize the release of any information required to complete my insurance claims and further authorize payment directly to Platinum Dental, Inc. for any benefits otherwise payable to me for their professional services. A copy of this authorization may be used in place of the original. To avoid misunderstanding regarding insurances, we wish our patients to know that all services rendered are charged directly to the patient and that the patient is **responsible for all fees not paid by the insurance company.**

Signature: _____
(Patient/Responsible party)

Date: _____



Name of Medical Doctor: _____ City: _____ Phone: () _____

Date of last medical Exam: _____ (Female only) Is there any possibility you are pregnant? No ☐ Yes ☐ _____ Months

Have you even had or do you have any of the following? Please check below.

- | | | |
|---|--|---|
| ☐ Heart murmur | ☐ Tired jaw muscles | ☐ Lung trouble (TB, asthma, emphysema) |
| ☐ Rheumatic fever | ☐ Dizziness/Loss of Balance | ☐ Kidney disease: _____ |
| ☐ Mitral Valve Prolapse | ☐ Earaches | ☐ Arthritis, Degenerative joint disease |
| ☐ Prosthetic joints / Heart Valves | ☐ Ringing in ears | ☐ Fainting spells, epilepsy, convulsions |
| ☐ Pacemaker | ☐ Ear stuffiness | ☐ Nervous breakdown/ anxiety disorders |
| ☐ Heart problems: _____ | ☐ Jaw pain | ☐ Indium, cobalt or Lithium treatment |
| ☐ High Blood Pressure | ☐ Neck pain | ☐ Radiation or chemotherapy |
| ☐ Stroke, when: _____ | ☐ Headaches/Facial Pain | ☐ Tumor or cancer |
| ☐ Blood trouble, anemia, leukemia | ☐ Clenching/Grinding | ☐ Shortness of Breath |
| ☐ Excessive bleeding | ☐ Change in bite | ☐ Venereal disease |
| ☐ Hepatitis: A or B or C or other | ☐ Jaw locking/catching | ☐ AIDS related complex |
| ☐ Diabetes: Type I or Type II | ☐ Jaw clicking/popping | ☐ Other: _____ |

Are you now taking medicines for: (please specify medication)

Have you ever been allergic to, been sick from, or been told not to take:

- | | | |
|---|---|---|
| ☐ Pain _____ | ☐ Heart _____ | ☐ Latex: _____ |
| ☐ Headaches _____ | ☐ Nerves _____ | ☐ Metals: _____ |
| ☐ Arthritis _____ | ☐ Sleeping _____ | ☐ Antibiotics (Penicillin, other): _____ |
| ☐ Allergy (asthma) _____ | ☐ Blood (thinners) _____ | ☐ Narcotics (Codeine, other): _____ |
| ☐ Stomach (ulcers) _____ | ☐ GERD _____ | ☐ Aspirin, NSAIDS: _____ |
| ☐ Thyroid _____ | ☐ Birth Control _____ | ☐ Anesthetics (Novocaine, other): _____ |
| ☐ Other _____ | | ☐ Other medications: _____ |

Do you have any disease conditions, or problems that are not mentioned above? _____

Do you smoke? No ☐ Yes ☐ If yes, how many cigarettes a day? _____ How many years? _____

Have you ever taken the diet drug combination, Fen-Phen? No ☐ Yes ☐ other diet drugs? _____

Referring Doctor's Name: _____ City: _____

Have you ever had or do you have any of the following?

- ☐ Orthodontic treatment _____
- ☐ Dental extractions _____
- ☐ Periodontal treatment _____
- ☐ Gum surgery _____
- ☐ Dental implants _____
- ☐ Gum disease _____
- ☐ Endodontics/Root canals _____
- ☐ Mouth guards/Sports guards _____
- ☐ Night guards _____
- ☐ Teeth whitening _____
- ☐ Sleep dentistry/general anesthesia/laughing gas
- ☐ Fear or anxiety related to dental treatment

What is the reason you are seeking TMJ care now?

- | | |
|---|---|
| ☐ Jaw Pain | ☐ Popping/Clicking |
| ☐ Closed Lock | ☐ Headaches |
| ☐ Open Lock | ☐ Stiffness/Tinnitus |
| ☐ Reduced/Deviated Range of Motion | ☐ Other: _____ |

What is your perceived level of pain/discomfort you are having now?

- ☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you gone anywhere else for your TMJ care? ☐ Yes ☐ No

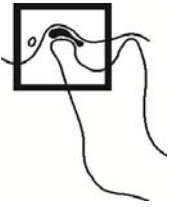
If yes, where? _____

Are you undergoing any Dental care currently? ☐ Yes ☐ No

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform the practice.

Patient Signature: _____ Date: _____

Patient Name (please print): _____



Sonny V. Eslampour, D.D.S.

555 S. Rancho Santa Fe Road, #100

San Marcos, CA 92078

Phone (760) 510-9009

Fax (760) 510-8008

www.platinumdental.com

www.tmj-therapy.com

Consent of Treatment

I hereby give consent to the doctors at Platinum Dental Inc. to take radiographs, study models, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I also authorize and consent the doctors to perform and employ any and all forms of treatment, medication, and therapy, which may be indicated in connection with my dental needs. I understand the use of anesthetic agents embodies a certain risk. You may obtain a copy of the "*Dental Material Fact Sheet*".

Signature (Patient/Responsible Party)

Date

HIPAA Consent of Disclosure

(For the Usage and /or Disclosure of Protected Health Information accordingly to the Health Insurance Portability and Accountability Act of 1966 (HIPAA))

I hereby give consent to Platinum Dental Inc. and all health care providers furnishing care with Platinum Dental Inc. to use and disclose my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Our posted Privacy Policy Notice (in reception room) provides more detailed information about the usage and disclosure of your Protected Health Information. You have the right to review our posted Privacy Policy Notice before you sign this consent.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will be only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our posted Privacy Policy Notice. You may obtain a copy of the current posted Privacy Policy Notice upon request.

I understand that this consent shall remain in force so long as I am a patient of this practice.

Signature (Patient/Responsible Party)

Date

Patient Name (Print)



OFFICE POLICY

We are committed to providing you with the best possible dental care. In order to promote a long-term mutual satisfying relationship we would like to explain our office policy regarding appointment, fees and insurance. Please read the following information.

REGARDING APPOINTMENTS:

INT___ When you schedule an appointment with us, please remember that this time has been reserved for you. When you fail to notify us of your inability to keep your appointment, another patient in need of dentistry is prevented from receiving treatment. A charge of \$50 will be made for failed or cancelled hygiene/re-care appointments without **24 hours** notice. A charge of \$75 will be made for every half hour of your scheduled appointment time for failed or cancelled restorative (i.e. fillings, crowns, veneers, RCT, and dentures, ect...) appointments without **24 hours** notice.

REGARDING FEES:

Payment for services is due at time services are rendered unless written payment arrangements have been approved.

INT___ For your convenience we accept cash, checks, Visa, MasterCard and Discover.
A \$6 sterilization/disposable fee will be collected at each appointment.
A returned check has a \$40 fee upon notification to us by the bank, and we require cash or credit card as alternative payments.
Duplication of X- rays has a \$35 fee, due prior to duplication process.
Unpaid balances over 30 days will be assessed monthly interests at the rate of 5% per month.
Unpaid balances over 90 days are subject to collection. If it becomes necessary to institute collection proceedings, I agree to pay any and all cost related to the collection action but not limited to, 30% collection agency fee, court costs and attorney fee.

We will gladly discuss your proposed treatment and answer any questions relating to your account. We will not perform any procedure without you knowing the estimated cost of the treatment upfront.

INT___ REGARDING INSURANCE:

As a courtesy to you, we can file your insurance claim on your behalf. A \$7 insurance processing fee will be collected for each claim.

As far as your insurance is concerned, please realize the following points:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. We do not render our services on the basis that insurance companies will accept or pay all our fees. Each fee is individual for the patient.

We must emphasize that as dental care providers, our relationship is with YOU, not your insurance company. If your insurance company fails to pay the portion they have estimated to pay, you are ultimately responsible for the balance due. ALL charges are your responsibility from the date services are rendered. In order to process your claim, we must have complete insurance information. If questions or concerns arise, we encourage you to contact us promptly for assistance in the management of your account. We are here to help you.

By signing your name below, you have read and understood our Office Policy.

Signature (Patient/Responsible Party)

Date

Patient Name (Print)



TMJ & Sleep Apnea Center

Platinum Dental, Inc.

New Patient Questionnaire

Patient Name: _____ Date: _____

1. What is the main reason for your visit with our office today?

2. How has your problem impacted your life or lifestyle?

3. How did you find out about your problem?

4. What treatments/therapies have you already had for this problem?

5. If you have had treatments or therapies for your problem, how effective were they in your judgment? (If multiple types of therapies, rate each separately)
A. Very effective B. Effective C. Somewhat effective D. Not at all effective
E. comments: _____

Continued ...



TMJ & Sleep Apnea Center

Platinum Dental, Inc.

6. Have you had a "sleep study" performed either in a sleep lab or at your home?

Yes No ☐ Lab ☐ Home ☐ ☐

A. If yes, what is the date of the sleep study? _____

B. Have you had a follow-up sleep study? _____

7. Check any of the following symptoms you are experiencing or have experienced in the past:

☐ jaw pain ☐ clicking/popping jaw joints ☐ headaches

☐ ear pain ☐ ringing in ear ☐ neck pain/shoulder pain/back pain

☐ difficulty/pain on chewing/swallowing

comments: _____

8. Do you wear dentures or other removable appliances in your mouth?

☐ No ☐ Yes : _____

9. Have you seen any other health care provider for this problem?

A. No B. Yes; (If yes, what type of health care provider?)

A. Dentist B. Medical doctor C. Sleep Specialist D. ENT specialist

E. Others: _____

10. How energetic are you upon waking up in the morning?

☐ Full of energy ☐ Normal ☐ Sluggish ☐ Tired

11. Do you snore? ☐ Yes ☐ No

12. Do you have high blood pressure or other cardiovascular disease?

☐ Yes ☐ No ☐ Don't know

13. How many hours of sleep do you get per night on average?

14. Do you work during the day or night?

15. How many times a night do you get up to use the restroom?