Fountain Plaza Family Dental
Wallace J. Bellamy, DMD

PATIENT FORM

NAME_____ SSN #_____ DATE OF BIRTH_____

ADDRESS _____ CITY _____ ZIP _____

HOME PH #_____ WORK PH #_____ CELL PH #_____

EMAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS: *(Check the boxes that apply)* □ **Married** □ **Single** □ **Widow** □ **Divorced**

EMERGENCY CONTACT _____ PH # _____

How did you hear about us? *(Check the boxes that apply)*

□ **Drive-by/Walk-In**
□ **Review Website**
□ **Google**
□ **Yelp**
□ **Facebook**
□ **Other**_____
□ **Referred by patient? If so, please list their name:** _____
□ **Referred by Dentist? If, so please list their name:** _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____ ID# _____
INSURANCE CO _____ PHONE # _____
GROUP # _____ GROUP NAME _____
EMPLOYER _____ OCCUPATION _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____ ID# _____
INSURANCE CO _____ PHONE # _____
GROUP # _____ GROUP NAME _____
EMPLOYER _____ OCCUPATION _____

□ **I AM NOT COVERED BY ANY DENTAL INSURANCE AT THIS TIME.**

MEDICAL HEALTH QUESTIONNAIRE

(This information is necessary for our files and your health and will be considered confidential)

PHYSICIAN'S NAME: _____ PH # _____

IF KAISER, LOCATION _____ KAISER # _____ LAST MED EXAM _____

PATIENT'S HEIGHT: _____PATIENT'S WEIGHT: _____

Has a physician ever directed you to take antibiotics prior to your teeth being cleaned or seeing the dentist?
□ **Yes** □ **No**

Have you ever taken bisphosphonates *(Fosamax, Reclast or Boniva)?* □ **Yes** □ **No**

Have you had any surgical procedures in the last three years? □ **Yes** □ **No**

If yes, please list: _____

_____

_____

Have you had an adverse reaction to local anesthetics? □ **Yes** □ **No**
Please list ANY allergies or adverse effects to any drugs or medications *(such as novocaine, xylocaine, iodine, aspirin, penicillin, codeine, fluoride, mouthwash, etc.)* food or **latex**: _____

_____

_____

Check any of the following conditions you have or have previously had:

□ **Heart Trouble**
□ **Heart Attack**
□ **Heart Murmur**
□ **High Blood Pressure**
□ **Mitral Valve Prolapse**
□ **Heart Valve Repair**
□ **Rheumatic Fever**
□ **Kidney Disease**
□ **Jaundice**
□ **Diabetes**
□ **Cancer/Tumors**
□ **Chemotherapy**
□ **Convulsions/Seizures**
□ **Dementia/Alzheimer's**
□ **Asthma**
□ **COPD**
□ **Snoring**
□ **Sleep Apnea**
□ **Drug Reactions**
□ **Phen-Fen**
□ **Arthritis**
□ **Joint Replacement**
□ **HIV/ARC/AIDS**
□ **Hepatitis**
□ **Herpes**
□ **Venereal Disease**
□ **Blood Disorders**
□ **Anemia**
□ **Acid Reflux**
□ **Stroke**
□ **Glaucoma**

Please list any disease, condition, or handicap not listed above: _____

_____

_____

Please list all medications you are taking: _____

_____

_____

_____

_____

Do you use tobacco or marijuana/cannabis? □ **Yes** □ **No** If yes, please check the following:

□ **Cigarettes/Vape** □ **Chewing tobacco** □ **Cannabis Cigarettes/Vape** □ **Cannabis edibles**
If so, how much per day? _____ And for how long? _____ Yrs.
Do you drink alcohol? □ **Yes** □ **No** If so, how many drinks per day? _____

WOMEN ONLY

Are you pregnant? □ **Yes** □ **No**
Are you nursing? □ **Yes** □ **No**
Are you taking birth control pills? □ **Yes** □ **No**
Have you undergone, or are you undergoing menopause? □ **Yes** □ **No**

DENTAL HISTORY

Are you having any dental pain or discomfort at this time? ☐ **YES** ☐ **NO**

Approximately how long has it been since your last dental appointment? _____

Name of previous dentist: _____

At this time, how do you feel about the condition of your dental health? _____

Do you use dental floss? ☐ **YES** ☐ **NO** How often? _____

Generally, how often do you brush your teeth? _____

Have you had any bad experiences in the past pertaining to dental treatment? _____

CONSENT

HIV/AIDS/HEPATITS TESTING

As a patient of *Wallace J. Bellamy, DMD*, I **AGREE/DO NOT AGREE (*circle one*)** to be tested for *HIV/AIDS/HEPATITS Viruses* in the event that anyone on staff at Fountain Plaza Family Dental is punctured by a needle or other sharp instrument while performing dental procedures on me. Furthermore, in order to protect the confidentiality of all parties involved, I agree to share results of such testing only with the affected employee's medical practitioner.

_____
Initials

INFORMATION DISCLOSURE AND ADDENDUM NOTICE

There have been changes recently to laws governing disclosure and storage of patients' health records and other personal information. The purpose of this notice is to inform you of your rights as a patient, as well as the steps we take to insure your privacy and to whom we disclose your private information.

First, please know that we take your privacy very seriously. We do not disclose your private information for marketing purposes of any kind! In the past, we have provided information to specialists when we referred our patients to them for treatment, such as dates of birth, social security numbers, and insurance information. Under the new legal constraints, we would have to obtain your written permission each time that we provide such information. The only time that we release your personal billing information is when we submit claims to your insurance carrier. Most insurance companies identify patients by their social security number and date of birth. Revealing your confidential treatment information is essential to getting the claim paid. If you would prefer not to give us your social security number, you are welcome to pay for your visit at the time of service by cash, or money order and we will provide you with the computer-generated form to bill your insurance company for reimbursement.

I authorize release of personal information to my insurance company(s) and assignment of benefits to Wallace J. Bellamy, DMD.

_____
Initials

If I decide to go to another healthcare provider, and that provider requests a copy of my x-rays/dental records be sent to them, I authorize release of those records.

_____
Initials

INFORMATION DISCLOSURE AND ADDENDUM NOTICE (CHILD)

As a patient, you have the right to review your child's records during our business hours with reasonable notice. Pursuant to California Health and Safety Code Section 12311(SB 1903), an adult patient may provide a written addendum, up to 250 words per item, to his or her dental record if the patient believes that the records are incomplete or inaccurate. The addendum then becomes part of the patient's record and must be attached and included when the record is disclosed to other parties. If you feel that your privacy has been maintained, or that our privacy procedures are inadequate, you have the right to file a written grievance with *Wallace J. Bellamy, DMD*.

I understand that I have the right to review and amend my Childs dental records, and that I have the right to file a written grievance if my Childs privacy is not maintained.

_____
Initials

PATIENT PHOTOGRAPH AND TESTIMONIAL AUTHORIZATION FORM

I herby give my consent for *Wallace J. Bellamy, DMD* to take photographs, slides, and/or videotape of my face, jaw, teeth. I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of the patient record.

If I have provided a written testimonial about my experience with *Wallace J. Bellamy, DMD*, the testimonial may be used in whole or in part as indicated below:

*Please circle **"do"** or **"do not"** for each statement and initial.*

I do/ do not consent to the use of these images in professional articles and presentations.

_____
Initials

I do/ do not consent to the use of these images within the dental practice to be seen only by individuals who walk into the practice.

_____
Initials

I do/ do not consent to the use of these images to promote the dental practice through various media, including but not limited to print advertising, brochures and the practice website.

_____
Initials

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise, from Wallace J. Bellamy, DMD. I hereby release and discharge Wallace J. Bellamy, DMD from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility of benefits.

_____ _____

Signature of Patient or Patient's Legal Guardian ***Date of Signature***

CONSENT

The undersigned hereby authorizes *Wallace J. Bellamy, DMD* to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I authorize *Wallace J. Bellamy, DMD* to perform any and all forms of treatment, medication and therapy that may be indicated in connection with ***(Name of Patient)*** _____ and further authorize and consent that Doctor choose and employ such assistance as she deems fit. I also understand the use of anesthetics embodies certain risks. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____	_____	_____
Signature of Patient or Patient's Legal Guardian	***Date of Signature***	***Reviewed by***

PATIENT SMILE EVALUATION

PATIENT NAME: _____ **DATE:** _____

1. Do you like the overall appearance of your teeth, your smile? **Yes □ No □**
   If NO, please describe: _____
   _____
2. Do you consider that your teeth are in good alignment (straight)? **Yes □ No □**
   If NO, please describe: _____
   _____
3. Do you have spaces between your teeth that you don't like? **Yes □ No □**
   If YES, please describe: _____
   _____
4. Do you like the color of your teeth? **Yes □ No □**
   If NO, please describe: _____
   _____
5. Do your teeth have unattractive stains? **Yes □ No □**
   - □ **Tobacco Stains** □ **Coffee/Tea Stains** □ **Discolored Fillings**
   - □ **Tetracycline Stains** □ **Silver Filling Stains** □ **Other**
6. Do you like the shape of your teeth? **Yes □ No □**
   If NO, please describe: _____
   _____
7. Do you think that your teeth are attractive? **Yes □ No □**
   - □ **Tobacco Stains** □ **Coffee/Tea Stains** □ **Discolored Fillings**
   - □ **Tetracycline Stains** □ **Silver Filling Stains** □ **Other**
8. Do you like the way your upper and lower teeth come together? **Yes □ No □**
   If NO, please describe: _____
   _____
9. Do you consider that your existing fillings or dental work is unattractive? **Yes □ No □**
   If YES, please describe: _____
   _____
10. Do you think your gums are unattractive? **Yes □ No □**
    - □ **Swollen** □ **Excessively Receded** □ **Reddened**
    - □ **Crowns are ill-fitting** □ **Bleed Easily** □ **Difficult to clean between teeth**
11. What would you like to change the most in the appearance of your teeth, you smile?

WALLACE J. BELLAMY. DMD (916) 683 - 3011 OFFICE@DRBELLAMYDMD.COM

APPOINTMENT GUIDELINES

Wallace J. Bellamy, DMD

We make every effort to value your time and we reserve your appointment time just for you. We consider all appointments confirmed once they are reserved.

We truly appreciate your courtesy of giving us ***48 hours' notice (2 business days, not including Friday - Sunday)*** if you have a conflict. We are committed to your oral health care and keeping your scheduled reservation allows us to be partners in your dental care.

We will waive your first missed reservation. However, a second missed reservation will require a deposit. The deposit will be applied towards your treatment. However, if you fail to keep that reservation, the deposit will be forfeited.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our Appointment Guidelines with you.

- I acknowledge an appointment is a reservation.
- I agree to provide a minimum of *48 hours' notice (2 business days, not including Friday - Sunday)* if I need to change my reservation.
- If I miss or change 2 reservations without the required *48 hours' notice (2 business days, not including Friday - Sunday),* I acknowledge that I will be charged $99/per reserved hour and will be required to pay a deposit at time of next scheduling.
- I acknowledge I am required to leave a deposit for any Nitrous Oxide procedures or Reservations over 2 hours in length.

_____ _____

Responsible Party or Patient (Print) Date

_____

Responsible Party or Patient (Signature)

OFFICE GUIDELINES

Wallace J. Bellamy, DMD

Our mission as individual dental professionals is to provide the highest quality of patient education and dental care to all patients that choose us for their dental care. Our hope is by providing you the following information we can prevent misunderstandings to ensure you encounter a positive experience. Please feel free to let us know if you have any questions or concerns.

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 an opportunity to plan for your dental care. We believe whether you privately pay or have dental benefits to assist you, everyone deserves the care they need and want. It is necessary to provide accurate insurance information so estimates can be as accurate as possible. _____

Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you be familiar with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within *45 days*. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite the processing of your claim. 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 dental insurance benefits, deductibles, limitations, or maximums. _____

Initials

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 confident smile. Please identify which form of payment is most convenient for you at the time of service.

Cash/Check ☐ MasterCard ☐ Visa ☐ Other Extended Payment ☐ *(Please see below)*

If eligible we offer extended payment plans thru our third-party providers: Sunbit or CareCredit. Please Note: A $25.00 NSF fee will be charged for all returned checks.

_____

Initials

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within *90 days*, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90 days may be subject to rebilling fee. _____

Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur. _____

Initials

Thank you for your understanding of the Office Guidelines!

My signature indicated that I understand the policies as outlined and any questions I have with regard to office policies have been answered.

_____ _____

Signature of Responsible Party or Patient 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

Financial Policy

Thank you for choosing us as your Oral Health Care Provider. We look forward to providing you with quality service and the best experience possible! To make this happen, we rely on your representation that you will pay our office for the services we provide. In hiring our office to provide you with dental services, you agree to the following terms:

1. **Regarding Insurance.** We DO NOT dictate or limit our treatment prescription based on your insurance coverage. YOUR INSURANCE BENEFITS ARE DETERMINED BY YOUR EMPLOYER, NOT YOUR DENTIST. Please be aware that some, and perhaps all, of the services may be non-covered services under the terms of your insurance policy. As a courtesy, we will be glad to file your claim for you if you bring in your insurance card and all required employer information. You will be expected to pay up front for services rendered if the office is unable to verify your insurance information before any treatment.
2. **Payment is due.** Payment is due on the day of service. In some cases, when scheduling appointments for treatment, you may need to make a pre-payment of at least ½ that day (dental laboratories need payment at the time of first impression) and the remaining balance will be due the day services are rendered. We are pleased to offer these options for payment: cash, check, and all major credit cards. We also offer Care Credit and Sunbit, an excellent third-party payment plan for treatment over $100. You are invited to discuss your treatment with our business team to determine the most convenient method of payment for your individual situation. You will be responsible for a $35 fee if checks are returned to our office.
3. **Collections.** Statements will be sent out as insurance claims are received and then again once every month. Failure to pay balance 30 days after receiving final payment from insurance company may result in a finance charge to that account. Finance charges will keep accumulating every month until balance is paid off. After 90 days, patients who have failed to either communicate with our office and/or make a payment are subject to being sent to collections. By signing below, I agree to pay all amount(s) owed within 90 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my current/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it shall remain my responsibility to pay all amounts owing as set forth herein. In the event any amount(s) is/are referred to a third-party collections agency, I agree that in addition to any other amount(s) allowed by law (such as interest, court costs, reasonable attorney's fees, etc.), I will also be responsible for a collections fee of 40% of the principal amount(s) owing as allowed by California code. The terms of the paragraph shall apply to all the amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I also agree to the office contacting me through email/text messaging in regards to my account.

Responsible party's name (print): _____ **Date:** _____

Responsible party's signature: _____

Relationship to patient (if patient is a minor): _____

Notice of Privacy Practices - HIPAA

This Notice describes how your health information 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 us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice took effect Nov 1st, 2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us at (916) 683-3011.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 activities.

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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions or disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, of if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payment for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health: We may, and are sometimes legally obligated, to discuss your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via text, voicemail, email, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use this format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Acknowledgement of Receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgement****

I, _____ have received a copy of *Wallace J. Bellamy, DMD's* Notice of Privacy Practices.

Print name: _____

Signature: _____

Date: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to patient: _____

For program use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other *(Please Specify)* _____

_____ _____
Witness Signature *Date*

_____ _____
Dentist Signature *Date*