PATIENT NAME:_____ BIRTHDATE: _____CHART#: _____

silicondental
FAMILY & COSMETIC DENTISTRY

Aborn Professional Center
2060 Aborn Road, Suite
San José, CA 95121

t:408.238.5500
f: 408.238.8855

Welcome

On behalf of Dr. Satbir K. Kahlon and our Dental Team, we are pleased to welcome you to the practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.
All information will be kept confidential.

Patient Information

Patient's Name: _____ I perfer to be called_____Sex____

Marital Status: □Single □Married □Divorced/Separated □Widowed

Birthdate: ___ / ___ /____ Age:_____ Social Security # _____-_____-_____ Drivers License #: _____
Address: _____ City: _____ Zip: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
E-mail: _____

Patients Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Person to contact in case of an emergency: _____ Phone: ( ) _____

Is the patient a student? □Full Time □ Part Time School: _____

Responsible Party's Information

Person Responsible for Account: _____ Relation to Patient_____

Home Phone: ( )_____ Work Phone: ( )_____

Mailing Address:_____ City: _____ Zip:_____

Social Security #: _____-_____-_____ Drivers License #: _____

Employer: _____ Occupation: _____

Employer's Address:_____ City:_____ Zip:_____

Have you or any member of your family been a patient at this office before? □YES□NO

If YES, Name: _____

Primary Dental Insurance: □YES □ NO

Insured's Name: _____

SS #: _____-_____-_____ DOB: ___/___/___

Employer: _____

Insurance Company/Plan: _____

Union/ Group Name: _____

Group or Policy #: _____ Local#:_____

Date Employed: _____

Secondary Dental Insurance: □YES □NO

Insured's Name: _____

SS #: _____-_____-_____ DOB: ___/___/___

Employer: _____

Insurance Company/Plan: _____

Union/ Group Name: _____

Group or Policy #: _____ Local#:_____

Date Employed: _____

Who may we thank for recommending our office to you? _____

Otherwise, how did you choose our practice? □ Insurance plan □Yellow pages □ Mailer/AD
□Other source: _____

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I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Has there been any change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam?_____Date of last dental exam?_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Recent weight loss, fever, night sweats?	20.	Yes	No	Headaches?
10.	Yes	No	Shortness of breath?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung disease?	46.	Yes	No	VD(syphilis/gonorrhea)
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies: drugs, foods, medication, latex?	49.	Yes	No	Thyroid, adrenal disease
39.	Yes	No	Fam. History:diabetes, heart disease, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood Transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	64.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies. Bisphosphonate, Fosamax, Zometa or Aredia	65.	Yes	No	Alcohol?

63. Yes No Have you ever taken Phen-Phen

Please list:_____
_____

VI. WOMEN ONLY:

66.	Yes	No	Are you or could you be pregnant/nursing?	66.	Yes	No	Taking birth control ?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____
_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change(s) in my health and/or medication.

Patient's Signature:_____Date:_____

Doctor's Signature:_____Date:_____

COMMENTS:_____

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Consent For Services & Office Policies

Financial and Insurance Policies:

It is our goal to provide our patients with leading edge dental technologies, the finest dental materials, and expert staff in a comfortable environment.

In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment at the time of their visit. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

A service charge of 1.5% (18% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any accounts past due over 90 days may be sent to a collection agency.
The fee estimate listed for dental care can only be extended for a period of six months from the date of patient examination.

Policies for X-rays and Dental Records:

X-rays in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination X-rays are generally taken once a year for adults and every six months for children. However, the frequency at which X-rays are taken will be based upon individual dental need.

Office Cancellation Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee.

Proposition 65:

The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTAL MATERIALS FACT SHEET". It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document please feel free to bring your questions to our attention.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Guarantor of payment/ responsible party

Signature for receipt of DENTAL MATERIALS FACT SHEET: _____
Signature for receipt of NOTICE OF PRIVACY PRACTICES: _____

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Notice of Privacy Practices

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect nor copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to restrict your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your doctor is not required to agree to a restriction that you may request. If doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Keep this copy for your records