Gordon W. Poelman
DDS, Inc.
Family, Cosmetic and Restorative Dentistry

NEW PATIENT INFORMATION

WELCOME

Thank you for choosing to partner with us in your dental health care. We want to welcome you and share some insights about what we do for our patients. The philosophy guiding our practice is as follows:

"Our purpose is to help people achieve that highest level of well-being appropriate for them and, in do so, to enhance the quality of their lives."

In other words, we help you to be or become as healthy as you choose. This is a major departure from your average dental office. Instead of telling you how healthy you should be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are 3 levels on which you may choose to be seen in our practice. Please check the level of care you feel is most appropriate for you at this time.

O Level 1: Reactive Care. Patients at this level are interested in solving more urgent problems and not interested in a more comprehensive exam or long-term planning. In addition, they typically want the treatment to be performed as inexpensively and efficiently as possible.

O Level 2: Proactive Care. Patients who choose this level of care generally want a thorough exam and want to be involved in the prevention of present and future dental problems. Typically, however they choose repair solutions that are not long term in nature.

O Level 3. Regenerative Care. Patients at this level have a high value for their dental health and appearance. They desire a complete dental exam and have a
desire to be informed of all findings and the potential consequences of each problem. Ultimately, they want to be involved in creating a long-term master plan for their dental health which includes choosing the longest lasting solutions to their problems.
Finally, what would you like us to know about you that will help us meet your needs?

PERSONAL

Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N
Home Phone_____ Cell Phone_____ Work Phone_____
Email_____
Preferred contact method [ ] HmPhone [ ] CellPhone [ ] WorkPh [ ] Email
Who can we thank for your referral? _____
Emergency Contact Name_____ Phone_____

ADDRESS

Check box if same for entire family [ ]
Address_____
Address 2_____
City_____ State_____Zip_____

Responsible Party

Your relationship to patient: [ ] Self [ ] Spouse [ ] Parent

Name_____
Address (if different that above) _____
Phone_____ SSN#_____
I agree to financial responsibility for the above patient. Signature_____

DENTAL HISTORY

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain:
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain:
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain:
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you wear dentures or partials?

MEDICAL HISTORY

☐Y☐N Under a physician's care now? Physician's name:_____Phone:_____

☐Y☐N Any hospitalization in the past 5 years?

☐Y☐N Any serious illnesses/surgeries?

☐Y☐N Use tobacco in any form? If Yes, Type:

☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

☐Y☐N Do you wake refreshed in the morning?
☐Y☐N Do you snore?
☐Y☐N Do you have morning tension/migraine headaches?
☐Y☐N Have you ever been diagnosed with Sleep Apnea
☐Y☐N Do you wear a CPAP device?
☐Y☐N Have you ever been diagnosed with TMJ

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST:
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN WITH DATES. (EXAMPLE: TYPE OF CANCER)

_____

_____

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN ☐CODEINE ☐IODINE ☐SLEEPING PILLS ☐NONE

☐ANESTHETIC – LOCAL ☐METALS ☐METAL SENSITIVITY ☐SULFA DRUGS
☐BARBITURATES ☐LATEX ☐NITROUS OXIDE SEDATION ☐PENICILLIN/OTHER ANTIBIOTICS
☐OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____

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 US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the 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.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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.
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 and 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 was 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.
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, the prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using 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 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 are required to do so by law.
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 officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (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. You may request that we provide copies in a format other than photocopies. We will use the 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 using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, an alternative format or a summary or explanation of your health information, our office will supply this to you for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 12, 2003. 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 disclose 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 an emergency).
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 you request.
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. **Electronic Notice:** If your receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
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 rights, 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 us communicate4 with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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 your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Our Office with any questions you have.
Telephone: (858) 487-1234 Fax: (858) 487-1235
Address: 15525 Pomerado Road, Suite D-6, Poway, CA 92064

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

FINANCIAL CONSIDERATIONS

CANCELLATION POLICIES AND PROCEDURES: Please provide our office with a 24-hour advance notice. Your account will be charged a cancellation fee of $100.00 if we are not provided with the 24-hour notice. If you do not call or show for your scheduled appointment you will be charged the full price for the scheduled service.

x _____ Patient Initials

INSURANCE
We are happy to assist our patients with dental insurance. As a courtesy service to you, we will complete all forms pertaining to your claims and send them promptly to your insurance company.

We ask that you read your policy guidelines, as you as the insured are responsible for any benefit limitations that apply to your plan. We provide billing as a courtesy to only and may not be aware of special limitations your specific policy guidelines may have.

Payment of your estimated portion is due at the time of service for any procedure. All crowns, bridges, partials or dentures must be paid in full on date of service.

UCR
UCR is the term an insurance company uses to refer to what they consider to be a "usual, customary and reasonable" fee. This fee is designed by the insurance company only, and does not necessarily reflect the fees of our practice or other dental offices in the area. Insurance companies do not give our office any information about their individual "fee ceilings" or "UCR" maximum benefit allowances. You as the insured are responsible for any fees over your insurance company fee allowances.

It is to your advantage to understand every aspect of your dental care and your insurance benefits. Please be aware that clinical finding may necessitate a change in the treatment plan, with possible changes in costs. It is our policy whenever possible to make definite financial arrangements before any treatment is started. For your convenience, we offer Visa, MasterCard, Discover, American Express and Care Credit services as well as cash and check.

_____
Print Name

_____
Signature

_____
Date

As many of you who have checked into a hotel lately know, you are asked for a credit card at the time you check in. This is an advantage for both you and the hotel, since it makes checkout faster and more efficient. We are going to implement a similar policy.

You will be asked for a credit card at the time you check in and the information will be held securely until your insurances have paid and made their determination of coverage. At that time any remaining balance owed by you will be charged to your credit card, and a copy of this will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out.

This in no way will compromise your ability to dispute a charge or an insurance company's determination of payment.

Co-pays will still be due at the time of visit.

I authorize Dr. Gordon Poelman to charge outstanding balances on my account and any additional family members listed below to the following credit card:

Card_____ Account number_____ exp:_____ CVC_____

Name (print as printed on card) _____

Signature _____ Date _____

Additional family members:_____