Huntington Beach Periodontics & Dental Implants
Justin Braga, D.D.S., M.S., A Dental Corporation
18821 Delaware Street, Suite #200 Office: (714) 587-9094
Huntington Beach, Ca. 92648

Health History Questionnaire

The following is confidential information and is for our records only. If you have any questions, please contact one of our staff members. We will be happy to help you.

Name (Last):_____(First):_____ Mr. Mrs. Ms. Dr.

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: Male Female Birthdate:_____S.S.#:_____

E-Mail Address (Used only for contacting you regarding your appointments):_____

Employer_____Occupation:_____

Spouse/Parent Name:_____Birthdate:_____S.S.#:_____

Person to contact in case of Emergency:_____Phone:_____

REFERRED BY_____

PREFFERED PHARMACY_____

Dental Insurance Claims Information

Dental insurance is a benefit purchased by or for the patient. We cannot be responsible for what you have purchased. As a courtesy we will fill out and file a claim for you, but you are responsible for the entire bill. If the information you supply is incomplete or inaccurate, you will be responsible for full payment to our office and filing with your insurance carrier will be your responsibility.

Insured Name:_____ Subscriber Name_____ SELF SPOUSE PARENT OTHER

Employer of Subscriber:_____ Birthdate of Subscriber:_____

S.S.# or ID of Subscriber:_____ Insurance Company Name:_____

Release and Assignment

I hereby authorize release of any information, including the diagnosis and records of any treatments or examination rendered, to my insurance company or companies. This release is solely for the purpose of facilitating billing and reimbursement, directly to the doctor, of benefits to which I am entitled.

SIGNATURE:_____DATE:_____

CONTINUED ON FOLLOWING PAGE

Medical History

ARE YOU ALLERGIC TO OR HAD A REACTION TO ANY OF THE FOLLOWING MEDICATIONS?

Allergy to Latex	□ Yes	□ No	Local Anesthetic (Novocain)	□ Yes	□ No
Penicillin	□ Yes	□ No	Other Antibiotics	□ Yes	□ No
Sulfa Drugs	□ Yes	□ No	Aspirin, Tylenol, Advil, Etc. (circle)	□ Yes	□ No
Barbiturates, Tranquilizers, Sleeping Pills	□ Yes	□ No			

What happens when you take these medications?_____

Any other medications you are ALERGIC TO not listed? If yes, please list: _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Antibiotics	□ Yes	□ No	Anticoagulants (Blood Thinners)	□ Yes	□ No
Sulfa Drugs	□ Yes	□ No	Advil	□ Yes	□ No
Cortisone (Steroids, in last 2 years)	□ Yes	□ No	Tranquilizers (Librium, Valium)	□ Yes	□ No
Insulin or Orinase (Diabetic)	□ Yes	□ No	Digitalis or other Heart Medications	□ Yes	□ No
Nitroglycerin	□ Yes	□ No	Decongestants	□ Yes	□ No
Aspirin	□ Yes	□ No	Tylenol	□ Yes	□ No

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:_____

_____

Please check YES or NO if you are being treated, or have been treated for any of the following:

□ Yes	□ No	Used Phen-Phen	□ Yes	□ No	Ulcers/colitis
□ Yes	□ No	If so, had EKG?	□ Yes	□ No	Kidney dialysis
□ Yes	□ No	Recent Illness	□ Yes	□ No	Bruise Easily
□ Yes	□ No	Heart disease	□ Yes	□ No	Had Heart Surgery
□ Yes	□ No	Heart Attack	□ Yes	□ No	Asthma
□ Yes	□ No	Glaucoma	□ Yes	□ No	Hives
□ Yes	□ No	Angina	□ Yes	□ No	Emphysema
□ Yes	□ No	Frequent swollen ankles	□ Yes	□ No	Tuberculosis
□ Yes	□ No	Chest pain on exertion	□ Yes	□ No	Lung Disease
□ Yes	□ No	Stroke	□ Yes	□ No	Recent cough or cold
□ Yes	□ No	High blood pressure	□ Yes	□ No	Nose obstruction
□ Yes	□ No	Low blood pressure	□ Yes	□ No	Rheumatic fever
□ Yes	□ No	Bronchitis	□ Yes	□ No	Chemotherapy
□ Yes	□ No	Heart Murmur	□ Yes	□ No	Hay Fever
□ Yes	□ No	Mitral Valve Prolapse	□ Yes	□ No	Sinus Trouble
□ Yes	□ No	w/ regurgitation	□ Yes	□ No	Allergies
□ Yes	□ No	Congenital heart lesions	□ Yes	□ No	Cancer
□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No	Radiation therapy
□ Yes	□ No	Heart Pacemaker	□ Yes	□ No	Arthritis / Rheumatism
□ Yes	□ No	Artificial Joints	□ Yes	□ No	Cortisone medication or ACTH
□ Yes	□ No	Blood Disease	□ Yes	□ No	Pain in jaw joints / TMJ
□ Yes	□ No	Anemia	□ Yes	□ No	Thyroid Disease
□ Yes	□ No	Bleeding tendencies	□ Yes	□ No	Glandular disease
□ Yes	□ No	AIDS / ARC / HIV+	□ Yes	□ No	Diabetes
□ Yes	□ No	Hepatitis A, B, C or other	□ Yes	□ No	Epilepsy
□ Yes	□ No	Infectious mononucleosis	□ Yes	□ No	Fainting spells or dizzy spells
□ Yes	□ No	Blood Transfusion	□ Yes	□ No	Cold sores
□ Yes	□ No	Liver disease / Jaundice	□ Yes	□ No	Active Herpes
□ Yes	□ No	Hemophilia	□ Yes	□ No	Venereal Disease
□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Alcohol/ Drug Addiction Treatment
□Yes	□ No	Psychiatric Care			
□ Yes	□ No	Do you smoke? How many per day?_____			
□ Yes	□ No	Are you on a special diet? What kind?_____			

Family Physician_____

Have you been hospitalized in the past 5 years? □ Yes □ No

If yes, what was the problem?_____

Are you presently under the care of a physician? □ Yes □ No

Doctor's Name / Address / Phone #_____

CONTINUED ON FOLLOWING PAGE

Females ONLY: Are you Pregnant? □ Yes □ No
Trying to become Pregnant? □ Yes □ No
Taking Oral Contraceptives? □ Yes □ No

DENTAL HEALTH

Please check YES or NO if you are being treated, or have been treated for any of the following:

□ Yes □ No Do you consider yourself in good dental health?
□ Yes □ No Do you think that your teeth are affecting your health in any way?
□ Yes □ No Are you dissatisfied with the appearance of your teeth?
□ Yes □ No Are you dissatisfied with your chewing ability?

Have you ever had:

_____Orthodontic Treatment (Braces)
_____Oral Surgery (Extractions)
_____Periodontal Treatment
_____Your bite adjusted
_____A bite plate or other dental appliances

□ Yes □ No Have you noticed any loosening of your teeth?
□ Yes □ No Does food tend to get caught between your teeth?
□ Yes □ No Do you suffer from pain and/or swelling of your gums?
□ Yes □ No Do your gums often bleed when you brush your teeth?
□ Yes □ No Do you have an unpleasant odor or taste in your mouth?
□ Yes □ No Are you missing any teeth?
Reasons: Decay ( ) Gum Disease ( ) Other ( )
□ Yes □ No Have missing teeth been replaced?
□ Yes □ No Do you have any soreness, pain, clicking or popping in the area in front of your ears?

When did you last have your teeth cleaned before this appointment?_____
How long before that?_____
How often do you see your dentist?_____
How often and when do you brush your teeth?_____
Do you use: Hand toothbrush ( ) Electric toothbrush ( )
What else do you use to clean your teeth at home? (Floss, toothpick, water pick, etc.)_____
How often?_____

CONSENT FOR TREATMENT

RISKS OF DENTAL PROCEDURES IN GENERAL: Dr. Justin Braga believes in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment as well as our financial policy.

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication prescribed and drugs administered may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol and other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work until recovered from their effects.

I hereby authorize Dr. Justin Braga, D.D.S., M.S., and whomever he may designate to perform any dental treatment necessary and to administer emergency care as needed. I agree to the use of local anesthetic. I have been informed of possible complications of dental procedures.

I authorize the performance of any laboratory, x-ray or other studies that may be used by Justin Braga, D.D.S., M.S., or his designated staff as deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize Justin Braga, D.D.S., M.S., and his designated staff, to perform all recommended treatment mutually agreed upon by me.

I authorize photos, slides, x-rays, or any other viewings of my care and treatment during or after its completion to be used in the advancement of dentistry through teaching or presentations. My identity will not be revealed to the general public without my permission.

CONTINUED ON FOLLOWING PAGE

In order to receive treatment, I contract that if there are any differences or disagreements between Dr. Braga, D.D.S., M.S., and myself, I will first present such differences or disagreements to Dr. Braga in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the Orange County Dental Society's peer review and agree to accept their resolution in lieu of pursuing remedies by way of litigation. In consideration of helping to keep costs of treatment and services as low as possible, I also understand that this agreement is binding on my heirs and other family members.

INITIAL BELOW:

_____ I understand and agree that I am fully responsible for payment of all services rendered on my behalf or my dependents, regardless of any insurance coverage that I might provide. I understand Dr. Braga's financial policy is that fees are due before or at the time of service. I further understand that unless otherwise coordinated, any balances on my account after 60 days will be assessed a finance charge of 1.25% APR.

_____ I understand that the contract I have with my dental insurance company is between the insurance company and myself, and does not involve Dr. Braga, but if I provide Dr. Braga's office staff with complete information relating to my dental insurance, they will assist me by submitting my claims and interceding on my behalf. I authorize Justin Braga, D.D.S., M.S., and his staff to release information to my insurance company or companies including diagnoses and records of any treatment or examinations rendered. I consent to have payments paid directly to Justin Braga, D.D.S., M.S., from my insurance company. All accounts with an insurance balance over **60 days** will be charged back to myself and I am responsible for the paying the balance. If the office receives additional monies from the insurance company, we will promptly credit your account.

_____ Our office requires 48-hour cancellation notice, or you will be charged $100 per hour of appointment time. This means you must call 24- hours ahead of your appointment time if you wish to cancel, NOT the night before or the morning of your appointment. Please do not wait for us to call and confirm your appointment and then cancel at that time.

We will answer any questions you may have.

Date:_____ Patient / Parent Signature:_____

HUNTINGTON BEACH
PERIODONTICS & DENTAL IMPLANTS

Justin Braga, DDS, MS

Board Certified in Periodontics & Dental Implants

Financial Policy

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

Dr. Justin Braga believes in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment as well as our financial policy. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services rendered is due at the time services are rendered unless payment arrangements have been approved by our staff. We accept cash, checks, all major credit cards, and Care Credit. Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.25% per month. **Charges will also be made for broken appointments cancelled without 48 hours advance notice for surgical/non-surgical appointments. Please note if you are more than 15 minutes late, please consider your appointment cancelled and you will be responsible for the failed appointment fee.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2) Our fees are generally considered to fall within the acceptable range by most companies up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80% of "U.C.R", "U.C.R." is defined as usual, customary, and reasonable. This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost and care in this area.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4) Please be advised that the **ONLY** insurance company this office is in network with is **Delta Dental PPO and Premier.** However, we accept **ALL** Dental PPO Insurance Plans and are happy to process your claims for you.
5) **Please note we are NOT Medicare providers therefore we will not bill Medicare. We have chosen to "Opt Out" of the Medicare Programs.**

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. We realized that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of our account.

Please be aware that you are ultimately responsible for any and all charges incurred in our office. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask. We are here to help you.

Patient_____ Responsible Party Signature_____ Date_____
Relationship to patient_____

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EMAIL/TEXT CONSENT

I _____ understand that unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

Please Select One:

A. _____ **I CONSENT** to and accept the risk in receiving information via email and or text. I understand I can withdraw my consent at any time

B. _____**I DO NOT** consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Signature: _____ Date:_____

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Huntington Beach Periodontics & Dental Implants

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the ***Huntington Beach Periodontics & Dental Implants*** Notice of Privacy Practices.

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 acknowledgement could not be obtained because:

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

HUNTINGTON BEACH
PERIODONTICS & DENTAL IMPLANTS

Justin Braga, DDS, MS

Board Certified in Periodontics & Dental Implants

Consent Form for Use or Disclosure of Patient Health Information

Instructions: *Please complete and provide to* ***Huntington Beach Periodontics & Dental Implants****. You may request a copy of this completed form. For questions, ask to speak with our privacy officer.*

I authorize *Huntington Beach Periodontics & Dental Implants* to use or to disclose to _____ [Recipient's Name] the health information of _____ [Patient's Name] for the purpose of Medical Consultation. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following:
Comprehensive Medical, Psychological, and Dental History Findings and Treatment Recommendations

This authorization is valid until: The Completion of Care Under Dr. Braga and/or Staff at Huntington Beach Periodontics & Dental Implants unless otherwise noted:

Signature: _____
Print name: _____

Date Signed: _____

Signed by: ☐ Patient ☐ Parent/legal guardian
☐ Personal representative of the patient — *describe the legal authority that permits the representation:*

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