MELINDA BECK DDS
GENERAL • COSMETIC • SENIOR CARE

Thank you very much for placing your trust in our office and we would like to extend a whole hearted WELCOME to you and your family. Choosing the right doctor and practice is an important decision and we appreciate you instilling your trust in us. As your new dental home, we strive to provide "concierge level care at a comfortable cost". A place you enjoy coming to; a warm feeling of comfort and ease knowing that we will take care of you like you are a member of our extended family.

Our mission statement first and foremost is:

> "…to serve our patients in a calm, comfortable atmosphere of trust and compassion. We are driven to be the best, love what we do and want you to feel good about visiting us. We strive to build long term relationships through quality dental care and are passionate about improving the health and wellness of our patients. Additionally, dentistry is not only the act of providing care, but also being an active community member through volunteer and support of local causes. We wish for a better life for everyone involved."

I have been in family practice for the last ten years and have a strong background in family and geriatric (senior) care providing all aspects of general dentistry. My goal is not to create a production oriented practice where the doctor jumps from room to room. I will take the time to explain treatment options and procedures, and ensure all questions are answered prior to treatment. We are a team and can reach dental health together. Having proudly served with the US Navy as a dentist in Japan, I also have experience treating fearful, PTSD and TMD/TMJ patients. Whether it is in the office, after hours or over the weekend, we are here to provide excellent care, ease concern and answer your questions whenever the need is there.

For your convenience, we have enclosed a health questionnaire and other pertinent new patient information. Please bring the enclosed forms (filled out) with you to your scheduled appointment and if you have any questions, feel free to call us at 949.396.3803. We look forward to meeting you and serving your dental needs now and in the future.

Very Respectfully,

Dr. Melinda Beck

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NEW PATIENT INFORMATION

Name: _____ Sex: M ☐ F ☐ DOB _____
Please Print First Middle Initial Last mm/dd/yyyy

Street Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Employer: _____ Occupation: _____ SS#: _____
Name of business if self-employed / if retired, previous occupation Type of business if self-employed

Person to contact in case of emergency: _____
Name Phone number

_____
Address Relationship

Financially Responsible Party Information: **(if you are a college student, please fill out information with parents as the responsible party)**

Name: _____ Relationship to patient: _____ DOB: _____
mm/dd/yyyy

Mailing Address: _____

Billing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____ SS#: _____
Name of business if self-employed / if retired, previous occupation Type of business if self-employed

Insurance: Primary Dental Insurance _____
Insurance Company Name

Employee Name: _____ Employee DOB: _____
mm/dd/yyyy

Relationship to Patient: _____ Employee SS#: _____

Insurance ID#: _____ Group ID#: _____

Employer: _____

Employer Address: _____

Insurance: Secondary Dental Insurance _____
Insurance Company Name

Employee Name: _____ Employee DOB: _____
mm/dd/yyyy

Relationship to Patient: _____ Employee SS#: _____

Insurance ID#: _____ Group ID#: _____

Employer: _____

Employer Address: _____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all form of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. **I agree to pay for all services rendered by this office.**

_____ _____ _____
Signature Relationship to Patient Date

_____
Printed Name of Patient or Guardian

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Medical History

Patient Name _____ DOB _____
Please Print First Middle Initial Last mm / dd / yyyy

Physician _____ Physician Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

☐ Yes ☐ No Are you under a physician's care now? If yes, please explain: _____

☐ Yes ☐ No Have you ever been hospitalized or had a major operation? If yes, please explain: _____

☐ Yes ☐ No Are you taking any medications, pills or drugs? If yes, please list current medications: _____

_____

☐ Yes ☐ No Do you take, or have you taken, Phen-Fen or Redux?

☐ Yes ☐ No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Yes ☐ No Are you on a special diet?

☐ Yes ☐ No Do you use tobacco?

☐ Yes ☐ No Do you use controlled substances?

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex
☐ Sulfa drugs ☐ Other If yes, please explain _____

Do you have, or have you had, any of the following? Please circle correct response.

AIDS/HIV Positive	Yes	No	Cold Sores/Fever Blisters	Yes	No	Glaucoma	Yes	No
Alzheimer's Disease	Yes	No	Congenital Heart Disorder	Yes	No	Hay Fever	Yes	No
Anaphylaxis	Yes	No	Convulsions	Yes	No	Heart Attack/Failure	Yes	No
Anemia	Yes	No	Cortisone Medication	Yes	No	Heart Murmur	Yes	No
Angina	Yes	No	Diabetes	Yes	No	Heart Pacemaker	Yes	No
Arthritis/Gout	Yes	No	Drug Addiction	Yes	No	Heart Trouble/Disease	Yes	No
Artificial Heart Valve	Yes	No	Easily Winded	Yes	No	Hemophilia	Yes	No
Artificial Joint	Yes	No	Emphysema	Yes	No	Hepatitis A	Yes	No
Asthma	Yes	No	Epilepsy or Seizures	Yes	No	Hepatitis B or C	Yes	No
Blood Disease	Yes	No	Excessive Bleeding	Yes	No	Herpes	Yes	No
Blood Transfusion	Yes	No	Excessive Thirst	Yes	No	High Blood Pressure	Yes	No
Breathing Problem	Yes	No	Fainting Spells/Dizziness	Yes	No	High Cholesterol	Yes	No
Bruise Easily	Yes	No	Frequent Cough	Yes	No	Hives or Rash	Yes	No
Cancer	Yes	No	Frequent Diarrhea	Yes	No	Hypoglycemia	Yes	No
Chemotherapy	Yes	No	Frequent Headaches	Yes	No	Irregular Heartbeat	Yes	No
Chest Pains	Yes	No	Genital Herpes	Yes	No	Kidney Problems	Yes	No

Leukemia	Yes	No	Recent Weight Loss	Yes	No	Swelling of Limbs	Yes	No
Liver Disease	Yes	No	Renal Dialysis	Yes	No	Thyroid Disease	Yes	No
Low Blood Pressure	Yes	No	Rheumatism	Yes	No	Tonsillitis	Yes	No
Lung Disease	Yes	No	Scarlet Fever	Yes	No	Tuberculosis	Yes	No
Mitral Valve Prolapse	Yes	No	Shingles	Yes	No	Tumors or Growths	Yes	No
Osteoporosis	Yes	No	Sickle Cell Disease	Yes	No	Ulcers	Yes	No
Pain in Jaw Joints	Yes	No	Sinus Trouble	Yes	No	Venereal Disease	Yes	No
Parathyroid Disease	Yes	No	Spina Bifida	Yes	No	Yellow Jaundice	Yes	No
Psychiatric Care	Yes	No	Stomach/Intestinal Disease	Yes	No			
Radiation Treatments	Yes	No	Stroke	Yes	No			

Have you ever had any serious illness not listed above? Yes No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient, Parent, or Legal Guardian _____ Date _____

(For Digital forms your printed name acts as your signature)

FOR OFFICE USE ONLY

History has been reviewed and verified by the doctor. All questions and concerns have been answered.

Signature _____ Date _____

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DENTAL HISTORY

Name: _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation
PLEASE CIRCLE

Yes No 1. Do you have a dental problem or concern? _____
_____

Yes No 2. Do you receive routine dental care?
Last visit _____
Treatment received _____
Last cleaning _____
Last x-rays _____

Yes No 3. Are you aware of any sores or growths in your mouth?

Yes No 4. Do your gums bleed?
5. How frequently do you brush? _____
When? _____
6. How often do you floss? _____

Yes No 7. Do you have sensitive or sore teeth?
To what? _____

Yes No 8. Does food catch between your teeth?

Yes No 9. Do you have loose teeth?

Yes No 10. Do you have frequent earaches or headaches?

Yes No 11. Are you unhappy with the appearance of your teeth?

Yes No 12. Have you lost any teeth?
Why? _____

Yes No 13. Were missing teeth replaced?
When? _____

Yes No 14. If teeth were not replaced, have you had problems with your appearance, or with chewing? _____
_____

Yes No 15. Do you have dentures?
How many sets have you had? _____

Yes No 16. Have you ever had problems or complications with past dental care? _____
_____

Yes No 17. Does your mouth feel dry?

Yes No 18. Do you often consume sweets?
☐ Candy/Mints/Gum ☐ Soda Pop
☐ Coffee/Tea with sugar ☐ Cough Drops

Yes No 19. Do you clench or grind your teeth (day/night)?

Yes No 20. Do you have problems chewing any type of food?

Yes No 21. Do you have any other questions or concerns about dentistry or your health? (*Please describe*) _____
_____
_____
_____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date _____

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Financial Policy

Thank you for choosing us for your dental health care. Your dental health is our first priority and we are committed to successful dental treatments for you and your family. It is our belief that patients should make informed decisions about their dental health care. Proper financial arrangements are vital to our success in delivering top quality dental care. The following is a statement of our financial policy, which **we require you read and sign prior to any treatment.**

Financial Policy

Prior to initiating any treatment, we will inform you of your financial status with our office. This will include providing you with an estimate of the cost of your treatment. When a significant amount of work is planned, we will provide you with a typewritten estimate, which will also include the amount we **anticipate** you insurance company will assist with. We invite you to call our office or stop by with any questions that you might have.

We wish to schedule your treatment at a pace that is financially comfortable to you. Occasionally, patients will request that work be spread out over months or even years. While this is acceptable in many cases, be aware that your oral health can change significantly in a relatively short amount of time. Therefore, regular comprehensive examinations (with x-rays as needed) will be performed.

Please take a moment to review the current financial options available through our office. Should you need assistance with financial options at any time, our team will be available to assist upon your request.

Payment Options

1. Payment in full is due on the day of each visit. To demonstrate our appreciation for patients who are prompt with full payment, we will extend a three percent (3%) reduction in the total fee when payment is received in the form of cash or check.
2. Payments may be available for treatment and patients who qualify
3. We require that all insurance co-pays be paid at time of service. As a courtesy, we will bill your insurance for services rendered. To do so, we must receive an updated copy of your insurance card at your first appointment. If necessary, we will submit a pre-determination of benefits request to your insurance carrier prior to treatment. This allows us to obtain an estimate of your dental benefits and an estimated amount your dental plan expects you to be responsible for. **While we help you in every way possible to obtain your maximum allowable insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us. Billing your insurance is done as a courtesy. Knowing your insurance benefits and any balance not paid by the insurance company remains your responsibility.**
4. Secondary Insurance: Having more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. We will gladly bill your secondary carrier. **Any balance not paid by your secondary insurance carrier remains your responsibility.**

Please remember that we are not a lending institution and any account that is 90 days past due from the original date of service will incur an eighteen percent (18%) annual interest rate.

A fee of forty dollars ($40) will be charged for short notice cancellations (less than 24 hours) and missed appointments.

A thirty-five dollar ($35) fee will be charged for all returned checks.

Usual and Customary Rates

We are committed to delivering the best quality dental treatment for our patients, and we charge what is usual and customary for our area.

I hereby authorize release of any information to my insurance carrier regarding my treatment. I also hereby authorize any insurance benefits otherwise payable to me to be paid directly to Melinda Beck, DDS for services provided. By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Policy. This agreement stays in force until I change it is writing.

_____

Name of Patient or Responsible Party (Please Print)

_____

Signature of Patient or Responsible Party (for digital forms your printed name acts as your signature) Date

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Acknowledgment of Receipt of Notice of Privacy Practices

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

Print Name

Signature (for digital forms your printed name acts as your signature)

Date

Do we have your permission to:

Leave a message on your answering machine	Yes ☐ No ☐
Confirm appointments	Yes ☐ No ☐
Remind you of your pre-med (if applicable)	Yes ☐ No ☐
Speak to household members concerning your dental care	Yes ☐ No ☐

Name of persons

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)

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How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____

Check or complete all that apply (please print clearly):

☐ Contact me by U.S. Mail at the following address: _____
☐ Contact me by email at the following email address: _____

For Phone and Text Communications:
This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: _____

☐ **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

☐ Call me
☐ Text me
☐ Call me and text me

Signature: _____ Date: _____

Please call the dental office right away if you get a new telephone number!

For Office Use Only:

☐ Consent revoked. Date/Initials: _____/_____
☐ Possible reassigned number. Date/Initials: _____/_____
☐ Confirmed accurate. Date/Initials: _____/_____ Date/Initials: _____/_____
Date/Initials: _____/_____ Date/Initials: _____/_____
Date/Initials: _____/_____ Date/Initials: _____/_____