Welcome

Steven J. SCHNEIDER, DDS

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Cell Phone #1 (_____) _____ Cell Phone #2 (_____) _____

Employer/School _____ Employer/School Phone (_____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

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

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (_____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– OVER –

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DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Steven J. SCHNEIDER, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Steven J. Schneider DDS

11770 Bernardo Plaza Court
Suite 260
San Diego, CA 92128

HIPAA Notice of Privacy Practice

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The HIPAA (Health Insurance Portability and Accountability Act) law allows for the use of the information for treatment, payment, or healthcare operations. I acknowledge that I have received a copy of Steven Schneider's HIPAA Notice of Privacy.

By signing this form you consent to our use and disclosureof your protected healthcare information. By signing this form I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not haveto agree to those cease
- The practice may condition receipt of treatment upon execution of this consent

I authorize the release of information including the diagnosis, records, x-rays, and claim information.

May we discuss your dental conditions with any member of your family or close person?

If YES, please name the family member(s) or persons allowed:

_____

Authorized person and relation to patient Phone number

_____

Authorized person and relation to patient Phone number

_____

Patient name (Signature) Date

Steven J. Schneider, DDS
General & Cosmetic Dentistry
11770 Bernardo Plaza Court Suite 260, San Diego CA 92128
T 858-592-0234 F 858-592-0243

Dental Practice Policy

Office Philosophy

We Appreciate and value your choice to see us. We are very proud that people like you have voted us "The Best Dentist in San Diego".

We are committed to giving you the best quality dental care found anywhere. We also want this to be the best experience you have had in a dental office. We do understand that you would probably rather be anyplace else other than a dental office and we will do our best to change your mind.

We also believe that a happy patient is an educated one. In our office, we have information on all procedures by way of videos and handouts. Please always feel free to ask any questions that you may have. We will answer all questions and will not proceed until we know that you understand the treatment and home care recommendations.

We also want patients to understand their role in their dental treatment and care. Because we are dealing with the body there can be many unforeseen conditions that we are here to help with. We need you to let us know about any concerns. Please also make sure to let us know about any medical conditions or medications and changes you may go through. If you can't follow any recommendations or instructions, please let us know so we can adapt your treatment personally.

Financial Policy

It has come to our attention that because of changes in insurance policies and the difference in dental offices that our patients need to know our office policies.

Payments and Billing

Non-Insured Patients: Payment is due at or before time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks. On treatment involving laboratory fee (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the remaining balance in three weeks. On extensive treatments, you may prefer to secure a bank, credit union or other third party financing for the entire amount and make payments to the lending institution.
In-Office Arrangements: These arrangements must be made before any treatment can commence. Please understand that there are financing fees of 18%. If payments are not made on time there are late fees applied just like any other financing plans.

Insured Patients: Your dental benefits are based upon a contract made between you or your employer and insurance company. Ultimately, you are responsible for all charges incurred in our office. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Because this is your plan, and there are new Federal Privacy Acts, we may not be able to obtain the information that you need.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change, therefore it is impossible to give a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. We highly recommend you request a pre-authorization for any sizable treatment plan.

We are "In Network" with a few dental plans. This means we have accepted a reduced fee for treatment for these patients. No other discounts can be given to patients on these plans. All the same insurance protocols are still in effect for these type of plans. We will bill your insurance as a courtesy. If your insurance does not pay within 60 days, our office reserves the right to request payment in full for services rendered. If we are successful in collecting payment from your insurance you will then be reimbursed.

All co-payments are due at the time of service. Because all estimates are just that, any portion of your treatment not paid by your insurance **will be due** after the insurance claim is paid.
Again, we will pre-authorize any treatment at the request of our patients. Please understand that the insurance company reserves the right to change what they pay after they have sent you a pre- estimate quote and it also may take up to 6 weeks for the insurance company to respond to the request.

PLEASE TURN THE PAGE AND SIGN

Finance Charge: A finance charge of 18% will be imposed on each item of your account which has not been paid within 30 days from the time the item was added to the account.

Returned Checks: There is a $50 fee for any checks returned by the bank.

Discounts: Patients are eligible for a 5% discount if you have no insurance.

Missed Appointment Fee: Our time is reserved exclusively for you. Patients who do not show up on time for an appointment, miss an appointment or cancel with less than 24 hour notice will be charged a $100 fee. On larger cases over $500, there will be a charge of 20% of the scheduled treatment amount. Patients with 3 missed appointments will be asked to transfer their records to another doctor.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer the collection of balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in San Diego County, California. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office becomes matter of public record.

Divorce: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Informed consent: Please read the informed consent forms for each procedure given at the time of service. If you have any questions, please ask.

After Hours Emergency Visits: In the event of an emergency after regular business hours, a $125 emergency fee will be charged for established patients in addition to necessary treatment fees. Patients who are not established in the practice will be charged a $250 after hours emergency fee.

Transferring Records: If you choose to leave our practice you will need to request that in writing and pay a reasonable copying fee of $35 if you want to have copies of your records sent to another doctor or organization. This is under a Federal Privacy Act. You authorize our office to include all relevant information, including payment history. If you are requesting your records to be transferred from another doctor or organization, you authorize us to receive all relevant information.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental/health insurance, or financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for any charges due to a personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patients Name:_____ **Patients Signature**:_____

Date:_____ **Responsible Party** (*if not the patient*):_____

I have read, understand, and agree to this office policy.