Welcome

You have just joined a special group of people-our patients. We are a complete dental care team specially trained to offer a wide range of dental services. Your health and comfort is our primary concern with our ultimate goal being prevention and control of dental disease. Our purpose is to provide complete quality dental care in a gentle caring atmosphere. In order for us to provide excellent patient care on a consistent basis, the following below is an outline of our office policies.

Yearly Health History Updates

We require a completed health questionnaire form each year as required by State laws. For your protection we must know the condition of your health. During your initial visit the doctor will perform a complete oral examination. This examination will include the necessary X-rays and other procedure required to make a thorough and accurate diagnosis. At your six month cleaning appointments the doctor will conduct a periodic dental examination.

Your Future Appointments

We believe every patient should understand the status of their dental condition and
What is required to restore their mouth to optimum health? After our examination we will discuss a practical treatment plan with you. This plan will tell us where we are going, approximately how long it will take to get there, and what the investment will be.

Emergencies

We are available for emergency care. We will take immediate steps to relieve any discomfort you or a member of your family may experience. If an emergency situation should arise, please call us as early in the morning as possible.

Insurance and Payment

Our fees are the same as other qualified dentists in our area, and are enough to cover the expense of a quality dental care practice... For your convenience we accept Master card and Visa. We also offer a cash discount, and are willing to make financial arrangements for extensive treatment. Your dental insurance is a contract between you and your company. We will be happy to help you claim all insurance benefits to which you are entitled. However you are ultimately responsible for your account.

Missed Appointments

Appointment times are reserved especially for you. If you come in late, the Doctor may request that you reschedule the appointment and you may be charged a fee of $75. If for any reason you should need to change your appointment, there will be no charge; provided you give us 48-hour notice *(We request notice of 48 hours for cancellation of appointments. If appropriate notice is not given, a charge of $75may be assessed to the patient's account. We understand that sometimes last minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the dentist.)*
Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Your Regular Dental Care

Our purpose is to provide the highest quality dental care and education to our patients in a comfortable environment.

A Smile Is For A Lifetime
We are dedicated to helping you maintain yours.

AVANTI DENTAL GROUP
5415 Camden Ave. Ste #35
San Jose, Ca. 95124
(408)266-4100 Tel
(408)266-4106 Fax

INFORMED CONSENT FOR DIAGNOSTIC AND PREVENTIVE SERVICES

PATIENT'S NAME _____

PROCEDURES_____

Comprehensive and Periodic Diagnostic Procedures

As part of your complete examination, we will look at and feel many of the structures of your head, neck, mouth and teeth in order to evaluate their condition.

We will use a blunt probe under the gums next to your teeth to screen for the presence of gingivitis or periodontitis, gum disease that can lead to tooth loss.

We will take a full set of X-rays (up to 18 X-rays) in order to show us conditions that are not visible by looking or feeling. Recent original films of acceptable quality may be substituted only if you can bring them with you. We will use modern digital X-ray processed that can reduce your radiation exposure by up to 80%. Depending on our other findings in this initial or periodic examination, we may also require models or photographs to give us complete information.

DENTAL PROPHYLAXIS

Treatment for the prevention of periodontal diseases or other dental diseases by the cleaning of the teeth in the dental office includes the procedures of DENTAL SCALING and DENTAL POLISHING. The treatment may include plaque detection, removal of supra (above the gums) and subgingival (below the gums) plaque and calculus (tarter), application of caries-preventing agents, checking the restorations and prostheses and correcting overhanging margins and proximal contours of restorations, and checking for food impactions.

BENFITS, ALTERNATIVES AND COMMON RISKS

Only with complete information can we develop an accurate diagnosis and treatment plan. There are no effective alternatives to these diagnostic and preventive procedures. There are no substantial risks from these procedures, though minor discomfort may be experienced by some patients. Risks associated with X-rays are always a concern, but modern equipment ensures a negligible exposure.

CONSEQUENCES OF NOT PERFOMING THESE PROCEDURES

Inadequate diagnosis and treatment may cause future pain, greater expense for later treatment, loss of teeth and medical risks.

Every reasonable effort will be made to ensure that your diagnosis and treatment is completed properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed diagnostic procedures that you understand this information and that all of your questions have been answered fully. I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me.

_____ _____

Patient's Signature or Guardian (if patient is a minor) Date

_____ _____

Witness Date

_____ _____

Dentist Date

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DENTAL TREATMENT CONSENT FORM

Patient Name

Please read and initial the items checked below and read and sign the section at the bottom of form

1. WORK TO BE DONE:

I understand that I am having the following work done

Fillings_____ ridges _____
Crowns_____ Extractions_____
Impacted teeth removed_____ General Anesthesia _____
Root Canals Therapy_____ Other_____

2. DRUGS AND MEDICATIONS: (Initials_____)

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction.)

3. CHANGES IN TREATMENT PLAN: (Initials_____)

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any all changes and additions as necessary.

4. REMOVAL OF TEETH: (Initials_____)

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authori e the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured aw. I understand I may need further treatment by a specialist or even hospitali ation if complications arise during or following treatment, the cost of which is my responsibility.

5. CROWN, BRIDGES AND CAPS: (Initials_____)

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I reali e the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, si e, and color) will be before cementation.

6. DENTURES, COMPLETE OR PARTIAL: (Initials_____)

I reali e that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I reali e the final opportunity to make changes in my new dentures (including shape, fit, si e, placement, and color) will be the teeth in wax try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

7. ENDODONTIC TREATMENT (ROOT CANAL): (Initials_____)

I reali e there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal ob ects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy.)

8. PERIODONTAL LOSS (TISSUE AND BONE): (Initials_____)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of patient or the Parent/Guardian If patient is a minor **Date**

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office will charge you for broken appointments and appointments cancelled without 48-hour advance notice. It is vital you give our office a 48-hour notice to avoid cancelled appointment charges. ($75.00 charge per reserved appointment.)

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____
Print Name

_____ _____
Signature Date

Name on Card _____ Circle Type: Visa /MasterCard

Card Number: _____ Expiration Date: _____

Payment Agreement
I agree to the terms of the following agreement and authori□e Avanti Dental to charge my above credit card on agreed payment amount and dates of payment.

_____
Patient signature

AVANTI DENTAL GROUP

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

1. PATIENT INFORMATION

*Date..... *Name..... (Last First Initial)

*I prefer to be called..... *Spouse/Guardian's Name.....

*Soc. Sec. #..... *Birth Date..... *E-Mail.....

*Sex: ☐ Male ☐ Female *Status: ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

*Address..... Apt#..... *Home Phone.....

*City..... State..... Zip..... *Cell Phone.....

*Employer..... *Business Phone.....

*Business Address..... *Occupation.....

*Who may we thank for referring you? .....

☐ Phone book ☐ Direct Mail ☐ Walk By ☐ Website ☐ Insurance Referral ☐ Other.....

*In case of emergency, who should we contact? ..... Phone..... Relationship.....

2. PRIMARY INSURANCE

*Name of Subscriber.....

*Relationship to Patient.....

*Birth Date.....

*SSN/ ID#.....

*Employer.....

*Insurance Company.....

*Insurance Co. Phone.....

3. SECONDARY INSURANCE

*Name of Subscriber.....

*Relationship to Patient.....

*Birth Date.....

*SSN/ ID#.....

*Employer.....

*Insurance Company.....

*Insurance Co. Phone.....

Gateway Dental Group is authorized to provide any insurance company(s), claim administrators and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits.

X_____ _____

Patient or authorized person's signature Date

4. PATIENT DENTAL HISTORY

	Y	N
*Do your gums bleed while brushing or flossing?...	☐	☐
*Are your teeth sensitive to hot, cold, or chewing?..	☐	☐
*Are your teeth sensitive to sweet or sour?.....	☐	☐
*Do any of your teeth hurt?.....	☐	☐
*Do you have any sores or lumps in your mouth?....	☐	☐
*Have you seen an orthodontist for treatment?.....	☐	☐
*Have you had any head, neck, or jaw injuries?.....	☐	☐
*Do you have frequent headaches?.....	☐	☐
*Do you clench or grind your teeth?.....	☐	☐

	Y	N
*Have you experienced any of the following problems?		
Clicking.....	☐	☐
Pain (joint, ear, side of face).....	☐	☐
Difficulty in opening or closing your mouth.....	☐	☐
Difficulty in chewing.....	☐	☐
*Do you wear dentures or partials?.....	☐	☐
*Do you bite your lips or cheeks?.....	☐	☐
*Have you had difficult extractions in the past?.....	☐	☐
*Have you had prolonged bleeding after extractions?.....	☐	☐

*Former Dentist.....City, Sate.....Date of last exam and x-rays.....

5. PATIENT MEDICAL HISTORY

*Physician Name……

*Date of last visit? ……

	Y	N
*Are you under medical treatment?.....	☐	☐
*Have you been hospitalized in the past two years?....	☐	☐
If Yes explain……..		
……		
*Are you taking any medication(s)?.....	☐	☐
If yes what medication are you taking……..		
……		
*Are you allergic to any medication or anesthetic?.....	☐	☐
If yes please list……..		
……		

	Y	N
*Have you taken Fen-Phen/Redux?.....	☐	☐
*Do you use tobacco?.....	☐	☐
*Do you use controlled substances?.....	☐	☐
*Do you use contact lenses?.....	☐	☐
*Do you have persistent cough or throat clearing not associated with a known illness?.....	☐	☐
*Are you allergic to Latex?.....	☐	☐
*Women Only:		
a) Are you pregnant or think you may be pregnant?.	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking oral contraceptives?.....	☐	☐
d) Have you taken any Osteoporosis Medication?....	☐	☐

*Do you have or have you ever had any of the following?

	Y	N		Y	N		Y	N
AIDS or HIV Infections……	☐	☐	Emphysema……	☐	☐	Mitral Valve Prolapse……..	☐	☐
Anemia……..	☐	☐	Epilepsy/ Convulsion…..	☐	☐	Psychiatric Care……..	☐	☐
Angina……	☐	☐	Fainting/ Seizures……	☐	☐	Radiation Therapy……..	☐	☐
Arthritis……	☐	☐	Glaucoma……	☐	☐	Respiratory Problems……..	☐	☐
Asthma……..	☐	☐	Hay Fever/ Allergies…..	☐	☐	Rheumatic Fever……..	☐	☐
Artificial Heart Valve……	☐	☐	Heart Attack……	☐	☐	Scarlet Fever……	☐	☐
Artificial Joints/ Implants…….	☐	☐	Heart Murmur……	☐	☐	Sexually Transmitted Disease….	☐	☐
Abnormal Bleeding/ Bruising…	☐	☐	Heart Disease……..	☐	☐	Shortness Of Breath……	☐	☐
Blood Disease……	☐	☐	Hepatitis, Type____.....	☐	☐	Stomach Troubles/ Ulcers……	☐	☐
Cancer……	☐	☐	High Blood Pressure…..	☐	☐	Stroke……..	☐	☐
Cardiac Pacemaker……	☐	☐	Jaundice……..	☐	☐	Swollen Ankles……	☐	☐
Chemical Dependency……...	☐	☐	Jaw Pain……..	☐	☐	Tuberculosis……	☐	☐
Chemotherapy……	☐	☐	Kidney Disease……..	☐	☐	Tumor or Growth on Head/ Neck	☐	☐
Congenital Heart Disease……..	☐	☐	Leukemia……	☐	☐	Thyroid Problem……..	☐	☐
Cortisone Treatments……	☐	☐	Liver Disease……..	☐	☐	Other……	☐	☐
Diabetes……	☐	☐	Low Blood Pressure……	☐	☐	……		

6. CONSENT FOR SERVICES & OFFICE POLICIES

* The undersigned herby authorizes doctor to take x-rays, study models, photographs or any other diagnostics aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
* I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient). I understand that using anesthetic agents embodies certain risks. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
* I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
* I understand that were appropriate; credit bureau reports may be obtained.
* I understand that it is my responsibility to advise your office of any changes in the information contained in this form.
* I, _____(Patient's Name) have received a copy of the Dental Materials Fact Sheet required by law.
* I, _____(Patient's Name) acknowledge that I received a copy of the HIPAA Privacy Practices.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

X_____ _____

Signature of Patient (or parent/guardian if minor) Date

Medical and Health History reviewed by Dr._____ Date_____