

# Patient Information

(please fill out and print)

AESTHETIC  
DENTISTRY  
OF  
NOE VALLEY

4162 24th Street  
San Francisco, CA 94114  
tel: (415) 285 7007  
www.aestheticsmiles.com

## Contact Information

Mr. / Mrs. / Ms / Miss / Dr. \_\_\_\_\_  
Last First MI

Single  Married  Child  Widowed  Partnered  Other

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ -\_\_\_\_\_-\_\_\_\_\_  
Date of Birth Social Security Number Driver's License Number E-mail

May we confirm future appointments by E-mail?  Yes  No

\_\_\_\_\_  
Street Address City State Zip

(\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Home Phone Work Phone Cell Phone

\_\_\_\_\_  
Employer Address

How did you find us/Referred by? \_\_\_\_\_

## Dental Insurance

In most cases, fees will be due in full at the time of services. If you have dental insurance, we will send a claim along with supporting documentation and/or x-rays to your insurance carrier on your behalf, indicating you have paid for fees in full and request that they reimburse you directly for whatever you are entitled to. The most important thing for you to know is the amount of your "calendar year maximum" which you can find by calling your insurance carrier directly.

## Dental Insurance Information

Patient's relationship to subscriber:  Self  Spouse  Child  Partner  Other

Primary Insurance  
Subscriber's Name \_\_\_\_\_  
Last First MI

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ -\_\_\_\_\_-\_\_\_\_\_  
Date of Birth Social Security Number Telephone

\_\_\_\_\_  
Subscriber's Employer Telephone

\_\_\_\_\_  
Insurance Carrier Group Name Group Number Subscriber/Insurance ID Number

\_\_\_\_\_  
Insurance's Street Address City State Zip Insurance's Telephone

# Patient Information (cont'd)

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## Secondary Dental Insurance Information

Patient's relationship to subscriber:  Self  Spouse  Child  Partner  Other

Primary Insurance

Subscriber's Name

\_\_\_\_\_ Last

\_\_\_\_\_ First

\_\_\_\_\_ MI

Street Address

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
Social Security Number

(\_\_\_\_)\_\_\_\_\_  
Telephone

Subscriber's Employer

\_\_\_\_\_ Telephone

Insurance Carrier

\_\_\_\_\_ Group Name

\_\_\_\_\_ Group Number

\_\_\_\_\_ Subscriber/Insurance ID Number

Insurance's Street Address

\_\_\_\_\_ City

\_\_\_\_\_ State

\_\_\_\_\_ Zip

(\_\_\_\_)\_\_\_\_\_  
Insurance's Telephone

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# Health History

(please fill out, print, and sign)

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We are a health centered dental practice. Thus we are concerned with your total well-being, not just your oral health. An essential part of our approach is a complete health history. Please, fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank you!

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician's name (MD) Date of last visit

Have you had any serious illnesses or operations?  Yes  No

If yes, please describe: \_\_\_\_\_

(For Women Only) Are you pregnant?  Yes  No If yes, approximate due date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please check if you have had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Anemia                 | <input type="checkbox"/> Yes <input type="checkbox"/> No - Cough, Persistent      | <input type="checkbox"/> Yes <input type="checkbox"/> No - Cough Up Blood      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Shortness of Breath    | <input type="checkbox"/> Yes <input type="checkbox"/> No - High Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No - Jaw Pain            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Special Diet           | <input type="checkbox"/> Yes <input type="checkbox"/> No - Arthritis              | <input type="checkbox"/> Yes <input type="checkbox"/> No - Kidney Disease      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Chem. Dependency       | <input type="checkbox"/> Yes <input type="checkbox"/> No - Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No - Diabetes            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Artificial Joints      | <input type="checkbox"/> Yes <input type="checkbox"/> No - Swollen Neck Glands    | <input type="checkbox"/> Yes <input type="checkbox"/> No - Heart Murmur        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Skin Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No - Asthma                 | <input type="checkbox"/> Yes <input type="checkbox"/> No - Epilepsy            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Mitral Valve Prolapse  | <input type="checkbox"/> Yes <input type="checkbox"/> No - Stroke                 | <input type="checkbox"/> Yes <input type="checkbox"/> No - Back Problems       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Fainting               | <input type="checkbox"/> Yes <input type="checkbox"/> No - Nervous Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No - Blood Disease       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No - Glaucoma               | <input type="checkbox"/> Yes <input type="checkbox"/> No - Pacemaker           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Thyroid Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No - Cancer                 | <input type="checkbox"/> Yes <input type="checkbox"/> No - Headaches           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Psychiatric Care       | <input type="checkbox"/> Yes <input type="checkbox"/> No - Tobacco Habit          | <input type="checkbox"/> Yes <input type="checkbox"/> No - Radiation Treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Heart Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No - Hemophilia             | <input type="checkbox"/> Yes <input type="checkbox"/> No - Tonsillitis         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Cortisone Treatments   | <input type="checkbox"/> Yes <input type="checkbox"/> No - Respiratory Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No - Tuberculosis        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Chemotherapy           | <input type="checkbox"/> Yes <input type="checkbox"/> No - Chest Pain             | <input type="checkbox"/> Yes <input type="checkbox"/> No - Rheumatic Fever     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Ulcer                  | <input type="checkbox"/> Yes <input type="checkbox"/> No - Circulatory Problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No - High Cholesterol    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Hepatitis              | <input type="checkbox"/> Yes <input type="checkbox"/> No - Scarlet Fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No - Fibromyalgia        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - Liver Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No - Venereal Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No - HIV                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No - AIDS                   | <input type="checkbox"/> Yes <input type="checkbox"/> No - Other Autoimmune Dx.   |  |

Please explain items checked YES: \_\_\_\_\_

## BEFORE ANY CLINICAL PROCEDURES, PATIENTS AT RISK OF INFECTIVE ENDOCARDITIS MUST BE PREMEDICATED

\_\_\_\_\_  
(initials if you are a woman of childbearing age) I have been informed that any antibiotics prescribed to me will reduce the effectiveness of Birth Control Pills

List any medications you are currently taking: \_\_\_\_\_

Have you EVER taken or are currently taking bisphosphonates (e.g. Fosamax)?  Yes  No

Have you EVER taken or are currently taking fenfluramine and phentermine (e.g. Fen-phen)?  Yes  No

ALLERGIES:  Aspirin  Barbiturates  Codeine  Local Anesthetics  
 Penicillin  Sulfa  Latex (gloves)  Other

- I hereby authorize the doctors or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize the doctors to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.
- I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
- The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Doctor's Signature Date

# Personal Dental History

(please fill out, print, and sign)

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Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_

When was your last dental and cleaning check up? \_\_\_\_\_

Purpose of today's visit \_\_\_\_\_

Have you consulted with any other dentist about this?  Yes  No

If Yes, what was discussed or done? \_\_\_\_\_

## Do you now have or have you ever had any of the following?

Yes  No - Gum disease

Yes  No - Clicking of popping jaw

Yes  No - Pain around ear

Yes  No - Loose or broken teeth of fillings

Yes  No - Sores, blisters or growths

Sensitivity to:

Yes  No - Cold

Yes  No - Sweets

Yes  No - Grind your teeth

Yes  No - Jaw Pain or tiredness

Yes  No - Lip or cheek biting

Yes  No - Food collection between teeth

Yes  No - Bad breath

Yes  No - Heat

Yes  No - Biting/Chewing

## Would you like to know what options are available to you to:

Yes  No - Create a more attractive smile

Yes  No - Look younger

Yes  No - Keep your teeth for life

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date

# To Request X-rays and Treatment Records from another Dental Office

*(please fill out, print, and sign)*

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To minimize your exposure to radiation, it is very important to know when you last had x-rays taken AND the type of x-rays. Please provide our office with this information prior to your appointment.

I, \_\_\_\_\_, hereby request and authorize

\_\_\_\_\_  
Practice or Dentist Name

to disclose and provide copies of any and all clinical treatment records and information concerning my care, that is in the possession of this person and entity to

Aesthetic Dentistry of Noe Valley  
4162 24th Street  
San Francisco, CA 94114  
415-285-7007

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

# Consent to Dental Procedures

*(please print and sign)*

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Before receiving treatment, you should ask the doctor about the procedure(s) recommended, and ask any questions you may have before you decide whether or not to give your verbal consent for the procedure(s) to be done. All dental procedures involve some risk of unsuccessful results and complications, and no guarantee is made as to the result of treatment. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment, including not having the treatment at all. You have the right to consent or to refuse any proposed procedure at any time prior to its performance. To keep you more comfortable during treatment you may receive a local anesthetic or possibly a sedative. In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. There is also a small risk of nerve damage as a result of a local anesthetic injection. Sedatives may temporarily make you drowsy or deduce your coordination. If you do take a sedative during the dental procedure, you will need assistance getting home.

## **X-RAYS**

Dental x-rays will be taken as necessary and appropriate for examination, diagnosis, consultation, and treatment.

## **DENTAL RECORDS**

The records, x-rays, photographs, models, and other materials relating to your treatment in the office of Dr. Krishnaiah are the property of the doctor. You have the right to inspect such materials and to request copies. You may request to have copies of your dental x-rays sent to another health care provider by signing a 'Release of Records' form.

## **CANCELLATION POLICY**

If you are unable to keep an appointment, you must notify the office at least 48 hours in advance. An appointment that is missed or canceled with less than 48 hours notice might result in a missed appointment fee. **TWO CANCELLATIONS OR NO SHOWS MAY BE CAUSE TO DISCONTINUE FURTHER TREATMENT.**

Your signature on this form certifies that you have read and understand the information provided, that you have received a copy, and that you accept the terms and conditions described above.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

# Arbitration Agreement

(please print and sign)

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**Article 1.** It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2.** a) Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whenever born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law. b) Treatment covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration. d) Other Doctors (If Applicable). Patient understands that he or she may at times receive treatment from one or more doctors who practice jointly with the undersigned doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such doctors practicing with the undersigned doctor will be subject to compulsory, binding arbitration. d.) Coverage of prenatal claims (if Applicable). Patient understands and agrees that, if Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

**Article 3.** a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Doctor to Patient, Patient will promptly notify Doctor so that Doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days. b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 90 days, Patient may initiate arbitration by notifying Doctor to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Doctor shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision. c) Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C. C. P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California including the provisions of the Medical Injury Compensation Reform Act of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State. d) Interpretation of Agreement. Any controversy concerning the interpretation or application of this Agreement itself shall also be submitted to arbitration in the manner provided above.

**Article 4.** Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from medical services rendered prior to revocation shall be subject to arbitration.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Dated

\_\_\_\_\_  
Signed

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Dated

\_\_\_\_\_  
Doctor

# Notice of Privacy Practice

(please print and sign)

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*This notice describes how health information from 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 03 / 15 / 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 notice effective for all health information 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.

## Uses and Disclosure of Health Information

We use and disclose health information about you for treatment, payment and healthcare options. For example:

**Treatment:** We may use and 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 provided 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 and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certifications, licensing and 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 other dental or medical providers. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written permission, we cannot disclose your health information for any reason except those disclosed in this notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member or other person designated by you to the extent necessary to help with your healthcare, but only if you agree that we may do so.

**Person 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, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in 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 filed 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 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.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

# Policy for Missed Appointments

*(please print and sign)*

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There is a \$100 charge for a missed appointment if not cancelled 48 hours in advance. This will not be covered by your insurance. You may also be dismissed from the office if you fail to show up for your scheduled appointment.

I have read, understood, and agree to the above charge for a missed appointment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date