PATIENT INFORMATION

*(This information is necessary for our files and will be considered **CONFIDENTIAL**)*

Patient's Name _____ Age _____ Patient's Birthday _____ ☐ Male ☐ Female
LAST FIRST INITIAL

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ For how long? _____ ☐ Own ☐ Rent
STREET CITY ZIP

Patient is: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow ☐ Minor Res. Phone (____) _____

Email _____ Cell Phone (____) _____

Social Security No. _____ Driver's License No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ Bus. Phone (____) _____
STREET CITY ZIP

Spouse's Name _____ Birthdate _____ Soc. Sec. No. _____

Employed by _____ How Long? _____ Occupation _____

Business Address _____ Business Phone _____
STREET CITY ZIP

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Res. Phone (____) _____
STREET CITY ZIP

☐ I have no physician

Physician _____ (____) _____
NAME ADDRESS CITY TELEPHONE

Former Dentist _____ (____) _____
NAME ADDRESST CITY TELEPHONE

Why are you changing dentists? _____

Purpose of appointment _____ Do you wish to speak to the doctor Privately? ☐ Yes ☐ No

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ (____) _____
TELEPHONE

Address _____ (____) _____
STREET CITY ZIP

PREFERENCE OF PAYMENT: Cash on day of treatment ☐ Visa No. _____
Expiration Date

☐ Mastercard No. _____
Expiration Date

Name of insurance company (primary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION LOCAL

Name of insurance company (secondary insurance) _____

INSURED PERSON'S NAME BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.

NAME OF GROUP DENTAL PLAN GROUP NO. PLAN NO. NAME OF UNION SOCIAL SECURITY NO.

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? (Yes) No

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination ..... Date_____
3. Are you now under the care of a physician? ..... Yes No
4. Have you ever had any serious illness or operation? ..... Yes No
5. Have you ever been hospitalized? ..... Yes No
6. Are you taking any ☐ medications ☐ drugs ☐ herbs? ..... Yes No

   If so, what? _____ What dosage? _____
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No If so, what? _____
8. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin

   ☐ Codeine; ☐ Latex ☐ Other..... Yes No

   If other, what drugs? _____
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No – answer all conditions.)

Y N Anemia	Y N Cold Sores	Y N Heart Ailments	Y N Joint Replacement	Y N Respiratory Disease
Y N Herpes	Y N Emphysema	Y N Cerebral Palsy	Y N Nervous Disorders	Y N Epilepsy or Seizures
Y N Stroke	Y N Rheumatism	Y N Drug Addiction	Y N Tumors or Growths	Y N Psychiatric Treatment
Y N Ulcers	Y N Chicken Pox	Y N Kidney Disease	Y N Allergies or Hives	Y N Hepatitis or Jaundice
Y N Diabetes	Y N Bruise Easily	Y N Chemotherapy	Y N Pain in Jaw Joints	Y N Difficulty Swallowing
Y N Arthritis	Y N Head Injuries	Y N Stomach Ulcers	Y N Artificial Prosthesis	Y N Congenital Heart Lesions
Y N Asthma	Y N Heart Failure	Y N Angina Pectoris	Y N Sickle Cell Disease	Y N X-ray or Cobalt Treatment
Y N Cancer	Y N Scarlet Fever	Y N Mental Disorder	Y N Cortisone Medicine	Y N Radiation Treatment of Any Kind
Y N Seizures	Y N Sinus Trouble	Y N Thyroid Disease	Y N Allergies to Metals	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Hay Fever	Y N Heart Murmur	Y N Fainting Spells	Y N Excessive Bleeding	Y N Acquired Immune Deficiency Syndrome
Y N Glaucoma	Y N Liver Disease	Y N Rheumatic Fever	Y N Mitral Valve Prolapse	Y N TMJ (Temporomandicular Joint) Disorder
Y N Tonsillitis	Y N Heart Attack	Y N Tuberculosis	Y N High Blood Pressure	Y N Down Syndrome
Y N Hemophilia	Y N Blood Disease	Y N Blood Transfusion	Y N HIV Related Complex	Y N Autism

11. Do you have any disease, condition or problem not listed that you think we should know about? Yes No
12. Do you wear a cardiac pacemaker, or have you had heart surgery? ..... Yes No
13. Do you smoke? If yes, how much? _____ ☐ Cigarettes ☐ Cigars ☐ Packs per day..... Yes No
14. Have you ever taken the drugs ☐ Phen-Phen ☐ Redux or any ☐ diet drugs ..... Yes No
15. (Women) Are you pregnant? If so, how many months? _____ Yes No
16. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
17. (Women) Do you take any birth control medication or hormones? ..... Yes No

Pt. Name_____

Pt. Name_____

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... **Yes** **No**
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... **Yes** **No**
3. Have you had any serious trouble associated with any previous dental treatment? ..... **Yes** **No**

   If so, explain. _____
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely? ..... **Yes** **No**
7. Would you desire to be pre-sedated? ..... **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Signature _____ **Date**_____

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges il be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing tome under my policy.

A service charge of 1½ % per month (18% per annum) (but in no event more than the maximum rate permissible under state la) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

We require 48 hour cancellation notice for all appointments. An $85.00 fee will be charged for a missed appointment.

Signed _____ Date _____

CONSENT FOR TREATMENT:

I herby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer such anesthetics, analgesics, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally competent.

Signed:_____

Date:_____ Relation ship to Patient_____

Lowe and Rossopoulos Dental Specialists

Pediatric Dentistry and Prosthodontics

Our staff welcomes you to our office and would like you to know that we are committed to providing you with the best possible dental care. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are over 1000 insurance plans in America. Therefore, it is impossible for our office to know and understand policies and benefits of your insurance plan. It is the responsibility of the patient to know and understand policies and benefits of his or her insurance. This includes referrals obtained and presented prior to services being rendered. Our staff will gladly discuss your proposed treatment charges and answer any questions pertinent to your insurance. We trust you understand the following:

1. Payments for services are due at the time services are rendered. We accept cash, checks, Visa, MasterCard and Care Credit. An extra charge may be made if the co-pay is not made at the time of service.

2. Your insurance contract is between you, your employer and the insurance company. We are not a party to the contract. If you are deemed ineligible for your insurance benefits at the time of service, you are responsible for payment of services. **WE ARE NOT PREFERRED PROVIDERS FOR ANY INSURANCE PLAN.**

3. Some insurance companies select certain services they will not cover and patients are responsible for paying for these services. We bill insurance daily, so you should expect a response from your insurance company within 45 days. If you have not heard from your insurance company in 45 days, please contact them.

4. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

5. A charge of $30.00 will be applied for any returned checks.

6. A charge of $35.00 plus 18.9% will be applied to all delinquent accounts being sent to 'collections'.

7. If unable to keep an appointment, kindly give **48 hours** notice. A fee will be **$85.00** charged for missed appointments.

If you have any questions about the above information, PLEASE do not hesitate to ask us.
We are here to help you and look forward to working with you.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Date _____ **Signature** _____

8135 S. Painter Avenue, Suite 202
Whittier, CA 90601
(562) 907-4522

802 Magnolia Avenue, Suite 105
Corona, CA 92879
(951) 371-8833

18824 Delaware Street, Suite 206
Huntington Beach, CA 92648
(714) 841-2319

Lowe and Rossopoulos Dental Specialists

Prosthodontics Pediatric Dentistry

Notice of Privacy Practices

Keeping patient information is a prime priority for all of us at Dr. O. Lowe and E. Rossopoulos DDS, Inc. As required by the Privacy and Security rules under the 1996 Health Insurance Portability and accountability Act (HIPAA), we are providing this privacy notice to individual patients who seek dental care at our offices. We hope this helps you understand how we handle the personal identifiable health information about you that we collect and may disclose. This notice also explains how you may instruct us to limit disclosing personal information about you as the patient.

Protected Health Information (PHI)

The personal information we collect about you comes from the following sources:

- Information we receive from you on the patient data and insurance coverage such as name, address, social security number, telephone number, occupation, spouse and relatives and insurance companies
- Information about you recorded by the interviewing personnel and doctor in regard to your past medical history, surgeries, allergies, medication, hospitalization, present illness, past treatment, etc.
- Information we receive from other health care facilities and doctor and dental offices such as biopsy reports, laboratory results, physician and dentist work-ups, doctor's correspondents, etc.

Our policies and practices to protect your privacy

We protect personal information we collect about you by maintaining physical, electronic and procedural safeguards that meet or exceed applicable law. Third parties who have access to personal information (especially insurance companies and referral physicians and dentists) must agree to follow appropriate standards of security and confidentiality. We train people who work for us how to properly handle personal information and we restrict access to it. As a current patient, you can rely on our commitment to keep your PHI private. Permitted by Privacy Rules, we may share personal information about you for the purpose of treatment, payment and internal health care operations such as communications with you, in addition to disclosure to the Department of Health and Human Services for compliance efforts and disclosure to you as the patient. We will not reveal your PHI, except those specially permitted by law, to any external organization, including your family, friends or relatives, unless we are provided with either your oral permission or your written authorization.

Disclosure of PHI permitted by law

HIPAA's Privacy Rule attempts to protect patient privacy without disrupting patient care. Therefore, the use and disclosure of PHI for treatment and payment activities are permitted without patient authorization, after applying verification, authentication and minimum necessary principles. Each requester for your PHI is recorded in a Record of Disclosure after providing name, address, telephone number and fax number, purpose for the request, and specific records requested.

Your privacy rights and choices

You, as the patient, may request by writing or in person a copy of your own records and may amend your health information as needed. Additionally, you have a right to request an Accounting of Disclosure in which a log of the individuals/entities with whom we have disclosed your information will be provided to you. Finally, you have a right to restrict any legal disclosure. You may, upon written request, separately notify us not to disclose information about you to any specific entity or individual and we will accommodate you.

I have been provided with this Notice of Privacy Practices. I have read it and I have no further questions.

Name of Patient (Please print.): _____ Date: _____

Signature of Patient/ Parent/Guardian_____

Witness_____

Lowe and Rossopoulos Dental Specialists

Specializing in Dentistry for all Ages

8135 S. Painter Ave. #202 Whittier, CA 90602 (562) 907-4522 802 Magnolia Ave. #105 Corona, CA 92879 (951) 371-8833
18822 Delaware Ave. #204 Huntington Beach, CA 92648 (714) 841-2319

Consent to Receive Phone Calls

In accordance with the The Telephone Consumer Protection Act of 1991 (TCPA) and Health Insurance Portability and Accountability Act (HIPAA), we may send information including protected health care information, demographic, or billing information that may individually identify you or the patient and that relates to past, present, or future health conditions and related health care services and payment for the purpose of treatment and billing. Our complete privacy practice policy is on display in our reception area. We appreciate your time in completing this document.

I, the parent /legal guardian/ Patient (please circle one)

_____

of _____

_____
(Please List All Children Patients)

consent to receive calls and texts from Dr. Oariona Lowe and Evangelos Rossopoulos, DDS, Inc. or companies acting on behalf of Dr. Oariona Lowe, D.D.S.,and Evangelos Rossopoulos, DDS Inc. for the protected healthcare information, accounting and other services to the above listed patient(s) at the phone number(s) below, including my wireless number which my agent or I have provided. I understand that I may be charged for such calls and texts by my wireless carrier and that such calls may be generated by an automated dialing system.

Home: _____ Wireless: _____

Work: _____ Other: _____
(Please List Phone Numbers)

Signature _____

Date: _____

FOR OFFICE USE ONLY Account #: _____

Evangelos Rossopoulos, D.D.S.
802 Magnolia Ave. Ste 105
Corona, Ca 92879
(951)371-8833

Patient Photograph and Testimonial Authorization Form

I hereby give my consent for Dr Evangelos Rossopoulos to take photographs, slides and/or

videotape of _____ face, jaw, and teeth.

I have provided a written testimonial about my experience with Dr Rossopoulos, the testimonial may be used in whole or in part as indicated below.

Please circle "do", or "do not" for each statement and initial.

I	do	do not	consent to the use of these images in professional articles and presentations. _____
I	do	do not	consent to the use of these images within the dental practice To be seen only by individuals who walk into the practice _____
I	do	do not	consent to the use of these images to promote the dental Practice through various media, including but not limited to Print advertising, brochures, the practice website and facebook. _____
I	do	do not	consent to the use of the testimonial within the dental practice To be seen only by individuals who walk into the practice _____
I	do	do not	consent to the use of the testimonial to promote the dental Practice through various media, including but not limited to Print advertising, brochures, the practice website and facebook. _____

By consenting to the use of these photographs and testimonial as described above, I do not expect compensation, financial or otherwise from Dr. Evangelos Rossopoulos. I hereby release and discharge Dr. Evangelos Rossopoulos from any and all claims and demands arising out of or in connection with the use of my name, photograph, personal testimonial, or other information provided by me, including any and all claims for libel and invasion of privacy.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

_____

Print Patient's or Legal Guardian's/ Representative's Name

_____ _____

Patient's or Legal Guardian's/ Representative's Name Date

ALERT!

Bisphosphonate Drug Notification

Please notify us if you are taking any of the following drugs in the bisphosphonate family:

Fosamax® (Alendronate)
Bonefos®, Ostac® (Clodronate)
Didronel® (Etironate)
Boniva® (Ibandronate)
Aredia® (Pamidronate)
Actonel® (Risedronate)
Skelid® (Tiludronate)
Zometa® (Zoledronate)

□ Yes, I am taking the above medication _____

□ No, I am not taking any of the above medications.

Patient Signature: _____ Date: _____