PATIENT INFORMATION

OARIONA LOWE, D.D.S. ❖ EVANGELOS ROSSOPOULOS, D.D.S.

PATIENT DATA

NAME:_____ DATE:_____
LAST FIRST MI

NICKNAME:_____ SEX: M F AGE:_____ BIRTHDATE:_____

MAILING ADDRESS:_____ OWN/RENT *How Long:*_____

CITY/STATE:_____ ZIP CODE:_____

NAMES AND AGES OF OTHER CHILDREN IN FAMILY:_____

FATHER'S NAME:_____

MARITAL STATUS: S M Sp D W DRIVER'S LICENSE #:_____

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

OCCUPATION:_____ HOME PHONE: ( )_____

E-MAIL ADDRESS:_____ CELL PHONE: ( )_____

BUSINESS NAME:_____ WORK PHONE: ( )_____

MOTHER'S NAME:_____

MARITAL STATUS: S M Sp D W DRIVER'S LICENSE #:_____

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

OCCUPATION:_____ HOME PHONE: ( )_____

E-MAIL ADDRESS:_____ CELL PHONE: ( )_____

BUSINESS NAME:_____ WORK PHONE: ( )_____

IS PATIENT: ☐ YOUR NATURAL CHILD ☐ ADOPTED (Please fill in next line.)

LEGAL GUARDIAN (if not parent):_____

PERSON TO BE NOTIFIED IN AN EMERGENCY (not parent):_____

RELATIONSHIP:_____ WORK PHONE: ( )_____ HOME PHONE: ( )_____

Dental History

Why have you brought your child to see the dentist?_____

Source of introduction: ☐Phone Book ☐School Exam ☐ Dentist ☐Relative ☐Friend ☐Patient

Whom may we thank for referring you?_____

1. Is this your child's first visit to the dentist? ☐ Yes ☐ No
2. If no, give the date of the last examination_____
3. Has your child ever had any of the following?
   - ☐ Bleeding gums ☐ Headaches ☐ Stained teeth ☐ Tooth abscess (gum boil)
   - ☐ Injury to teeth ☐ Toothaches ☐ Frequent sore throats ☐ Cold sores (fever blister)
   - ☐ Bad breath ☐ Clicking, popping or pain in jaws
4. Does your child have habits which might affect oral health? (Check if YES)
   - ☐ Clenching or grinding teeth ☐ Pacifier ☐ Lip biting ☐ Mouth breathing
   - ☐ Tongue thrust ☐ Finger or thumb habit ☐ Other (describe)_____.
5. Is fluoride taken in: ☐ Water ☐ Vitamins ☐ Pills ☐ Gels ☐ Liquid rinse ☐ Not taken

Pt. Name_____

OARIONA LOWE, D.D.S. ❖ EVANGELOS ROSSOPOULOS, D.D.S.

Medical History

1. Does your child have any health problems? ☐ Yes ☐ No
   If yes, please explain_____
2. Were difficulties encountered during pregnancy or delivery of child? ☐Yes ☐No
   If yes, please explain_____
3. Did your child have a history of health problems at birth or during initial years? ☐Yes ☐No
   If yes, please explain_____
4. Is your child taking any medications or drugs at this time? ☐Yes ☐No
   If yes, please explain_____
5. Has your child ever had an unfavorable reaction to foods, drugs (codeine, penicillin) or other medications? ☐Yes ☐No
   If yes, please list_____
6. Has your child ever been hospitalized or seriously injured? ☐Yes ☐No
   If yes, date and reason_____
7. Does your child have any limitations in sports activities? ☐Yes ☐No
   If yes, please explain_____
8. Please check if your child has had any of the following:

Y N Anemia	Y N Cold Sores	Y N Cleft Lip/Palate	Y N Psychiatric Treatment	Y N Breathing or Lung Problems
Y N Herpes	Y N Down Syndrome	Y N Cerebral Palsy	Y N Nervous Disorders	Y N Food or Seasonal Allergies
Y N Jaundice	Y N Epilepsy or Seizures	Y N Drug Addiction	Y N Tumors or Growths	Y N Vision Problems
Y N Cancer	Y N Chicken Pox	Y N Kidney Disease	Y N Hepatitis or Jaundice	Y N Infectious Diseases
Y N Diabetes	Y N Bruise Easily	Y N Chemotherapy	Y N Pain in Jaw Joints	Y N Difficulty Swallowing
Y N Autism	Y N Head Injuries	Y N Stomach Ulcers	Y N Artificial Prosthesis	Y N Headaches- frequent
Y N Asthma	Y N Heart Failure	Y N Allergies or Hives	Y N Hearing Loss/ Impairment	Y N Pregnancy
Y N Hypertension	Y N Scarlet Fever	Y N Mental Disorder	Y N Developmentally Delayed	Y N Radiation Treatment of Any Kind
Y N Seizures	Y N Sinus Trouble	Y N Thyroid Disease	Y N Delayed Speech Development	Y N Venereal Disease (Syphilis, Gonorrhea
Y N Hay Fever	Y N Heart Murmur	Y N Fainting Spells	Y N Excessive Bleeding	Y N Drug Allergies
Y N Pregnant	Y N Heart Condition	Y N Rheumatic Fever	Y N Mitral Valve Prolapse	Y N Growth Problems
Y N Tonsillitis	Y N Sickle Cell Disease	Y N Tuberculosis	Y N Psychiatric Treatment	Y N Genetic Syndrome/disorder
Y N Hemophilia	Y N Blood Disease	Y N Blood Transfusion	Y N HIV Related Complex	

☐Other, please explain_____

9. Date and reason for last medical examination_____
10. Does your child have problems with: ☐Speech ☐ Learning ☐Concentration ☐Cooperating ☐Understanding
    ☐Other_____
11. Does your child get motion/car sickness? ☐Yes ☐No
12. Do you think your child will be a cooperative patient? ☐Yes ☐No
13. How do you discipline your child?_____
14. Has your child had vaccinations? ☐Polio ☐Tuberculosis test ☐Measles ☐HIB ☐DPT (Diphtheria, whooping cough, tetanus)
15. Is there additional information or comments we should know?_____

Name of Pediatrician or Family Physician:_____

Address:_____Phone: ( )_____

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

Date:_____Signature:_____

Year 2 Date:_____Signature:_____Changes in Health:_____

CONSENT FOR TREATMENT

My signature below indicates that I understand and have answered all questions on the personal/medical/dental history to the best of my knowledge and freely consent to the performance of any additional tests or procedures which are deemed necessary after a complete clinical examination. I have been informed that these procedures will be discussed with me prior to their taking place.

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

Signature (parent/guardian)_____Date:_____

Relationship to patient:_____

Lowe & Rossopoulos Dental Specialists

Creating smiles at every age & stage of life

Oariona Lowe, DDS • Evangelos Rossopoulos, DDS

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

ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes payment of whatever benefits may be due to the undersigned by check drawn to the order of the dentist to the extent of the dentist's charges itemized by statement attached and I authorize release of any information relative to the dental condition or treatment needed.

Date:_____ Signed:_____

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

FINANCIAL INFORMATION

Person responsible for this account:_____ Relationship:_____

Address:_____ Telephone:_____
STREET CITY ZIP

PREFERENCE OF PAYMENT: ☐ Cash on day of treatment ☐ Visa No.:_____
☐ Check ☐ Mastercard No.:_____

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 LOCAL

TERMS & CONDITIONS

I understand that financial arrangements must be made in advance as a condition of treatment by this office. 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 will be paid by an insurance company.

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

A service charge of 1_ % per month (18% per annum) (but in no event more than the maximum rate permissible under state law) 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 the 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 (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 attorneys' 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.

Signed:_____ Date:_____

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** _____

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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
Prosthodontics Pediatric Dentistry

COMPOSITE "WHITE PLASTIC" FILLINGS

I understand that composite, white, "plastic" fillings placed on children's teeth especially on the front teeth are strictly a cosmetic restoration. I understand that these fillings may break, discolor, stain, and fracture depending upon my child's habits (e.g., foods he/she eats, trauma, objects the child may place in his or her mouth to bite on). If a white facing is placed on a stainless steel backing this facing may come off. The stainless steel surrounding may come off and need to be recemented into place.

I understand that if these fillings do break and need to be replaced, an additional fee will be charged.

Name of Patient_____

Name of Guardian_____

Behavior Management/Pre-Medication

I understand that due to my child's age and level of cooperation, my son/daughter _____ will need to be pre-medicated with a tranquilizer prior to his/her dental appointment.

The Behavior Management Fee, which includes the use of a papoose board, pre-medication, and/or voice control by the dentist, is my responsibility. I understand that this is not a benefit covered by most insurance companies. I also understand that if nitrous oxide analgesia is used, it is also not a covered benefit.

Parent/Guardian_____ Date_____

DENTAL PREMEDICATON INSTRUCTIONS FOR YOUR CHILD'S VISIT TO THE PEDIATRIC DENTIST

1. **Do not let the child have any food or drink, especially milk, after 12:00 p.m. the night before the dental visit.**
2. **Depending on your child's weight and age, they may be given a tranquilizer. This does not put the child to sleep; it only makes them feel groggy. Utilization of a tranquilizer will be discussed with you prior to its use.**
3. **This tranquilizer may be administered to your child the evening before the dental visit and again 1-2 hours prior to the dental appointment. You will need to be prepared to watch your child for about 60 minutes to 1-½ hours or so, until the tranquilizer goes into effect.**
4. **Following your child's dental visit, you must watch the child for approximately 3 hours until the effects of the tranquilizer wear off.**

Dr Oariona Lowe
802 Magnolia Ave, Ste 105
Corona, CA 92879
(951)371-8833

Patient Photograph and Testimonial Authorization Form

I hereby give my consent for Dr Oariona Lowe to take photographs, slides and/or videotape

of _____ face, jaw, and teeth.

I have provided a written testimonial about my experience with Dr Lowe, 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. Oariona Lowe. I hereby release and discharge Dr. Oariona Lowe 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

Lowe and Rossopoulos Dental Specialists

Specializing in Dentistry for all Ages

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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 #: _____