Elona Gaball, DDS

WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

Name:_____ Date:_____
Last First Middle Initial

Social Security #: _____ Birthdate: _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Office Phone ( ) _____

Mobile Phone ( ) _____ Other Number ( ) _____

Sex: ☐ M ☐ F ☐ Minor, ☐ Single, ☐ Married, ☐ Divorced, ☐ Separated, ☐ Widowed, ☐ Other

Emergency Contact & Phone: _____

Referred By: Another Patient ☐; Work ☐; A Friend/Co-Worker ☐; An Ad☐; Other ☐ _____

Employer _____ Occupation: _____

E-Mail Address:_____ May we contact you at this e-mail? Y N

PRIMARY DENTAL INSURANCE

Person Responsible for Account: _____
Last First M.I.

Relationship to Patient _____ Birthdate _____ SS # _____

Insurance Company _____ Group # : _____

Subscriber ID: _____

SECONDARY DENTAL INSURANCE

Person Responsible for Account: _____
Last First M.I.

Relationship to Patient _____ Birthdate _____ SS # _____

Insurance Company _____ Group # : _____

Subscriber ID: _____

ADDITIONAL (SECONDARY) INSURANCE FILING & FINANCIAL INFORMATION

You may be covered by more than one insurance plan. Our office will automatically bill your secondary insurance as a courtesy to our guests, if you provide us with the necessary information. However, we are unable to determine what your second insurance will pay. Therefore, all co-pays will be based upon your primary insurance benefits only.

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Elona Gaball, D.D.S. and/or Dr. Elona Gaball Professional Dental Corporation for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

BROKEN APPOINTMENT POLICY

Broken appointments (failure to show for an appointment) or cancellations without 48 hours notice are subject to $45 fee. Leaving a message the night prior, or on an immediately preceding weekend or holiday to cancel an appointment will be considered a broken appointment.

FINANCIAL POLICY

I understand that Elona Gaball, D.D.S./Dr Elona Gaball Professional Dental Corporation will charge me a finance charge at a periodic rate of 10% per month billed monthly if I do not pay my balance in full within 30 days of the billing date. After 60 days additional fees may apply. In the case of default of payment, I promise to pay any additional charges on the balance due, together with collection costs and any attorney fees incurred to effect collection on this account. A $25 fee will be for checks written with insufficient funds.

By signing I acknowledge that the patient information herein is accurate and I understand and agree with all of the above.

Signature of Responsible Party _____ Date _____

HEALTH HISTORY

Name _____ Date _____

Approximate date of last health care exam: _____What was this exam for?_____

If you were hospitalized in the last 5 years, what was the reason? _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list the name and number of the physician who is currently providing you care:
_____ Phone: _____

*For the following questions **circle** yes or no.*

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes? If yes, last HgA1C: _____	No	Yes	Mental or Psychiatric problem	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart/Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease (STD)	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Medications:

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?	No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?	No	Yes
Pre-medication before dental treatment?	No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any energy drinks, dietary or herbal supplements you are taking, and for what purpose:

1._____ 2. _____
3._____ 4. _____

Women only:

Are you pregnant? ……	No	Yes
If no, are you planning a pregnancy in the near future? ……	No	Yes
Are you a nursing mother? ……..	No	Yes
Are you taking birth control pills? ……..	No	Yes

HEALTH HISTORY
(Continued)

Have you ever received a diagnosis of "high blood pressure" …….…….. No Yes
Do you have abnormally low blood pressure? …….…….. No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin, Ibuprofen or Tylenol …..…… No Yes
d. Codeine, Valium® or other sedatives…….. No Yes
e. Latex or Metals
f. Other (specify)_____

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Additional Information:

_____
_____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Dr. Gaball has my permission to ask the respective health care provider or agency, who may release such information to Dr Gaball. I will notify Dr. Gaball of change in my health and/or medication.

_____	_____	_____
Patient (Print Name)	**Patient Signature**	**Date**
_____	_____	_____
Doctor (Print Name)	**Doctor Signature**	**Date**

DOCTOR'S COMMENTS:

_____
_____
_____

Elona Gaball, DDS

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(858) 876-9100

GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about treatment (therapy) we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to tell you of the risks that may occur in dental treatment, and other treatment choices.

RISKS OF DENTAL PROCEDURES IN GENERAL: include (but not limited) are complications resulting from use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, tempromandibular (jaw) joint difficulty, and headaches, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: 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. If any changes are needed they will be explained. After that explanation, if I agree verbally or in writing, I give my permission to the Dentist to make any/all changes, additions, and /or deletions, as the Dentist deems necessary.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment, which I am requesting and authorizing. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, individual, or corporation, other than the treating Dentist, is responsible for my dental treatment. In order to receive treatment I contract that if there is any difference or disagreement between my attending dentist and myself, I will first present such difference to my attending dentist to resolve the problem to a reconciliation board such as the grievance committee of my dental health plan, or California State Consumer Affairs Board of Dental Examiners, and agree to accept their resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

Alternatives and other possible untoward reactions will be explained to me in detail and clearly, including (but not limited to) bleeding, scarring, numbness, fractured jaw, and allergic reactions which on occasion can be life threatening. **I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE TO ME.**

Patient or Legal Representative Date

Elona Gaball, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I have received or been offered a copy of this office's Notice of Privacy Practices.

_____ _____

{Signature} {Date}

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

Email Address: _____

I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
Signature: _____ Date: _____

I consent to only receiving appointment reminders via email or text. I understand I can withdraw my consent at anytime.
Signature: _____ Date: _____

I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.
Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Other (Please Specify) _____

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The Dental Board of California Dental Materials Fact Sheet

As required by Chapter 801, Statutes of 19092, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and the dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." Additional information is available at http://www.dbc.ca.gov, in the office, or on Dr. Gaball's website to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influence by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Patient Acknowledgement of offer to receive a copy of the Dental Materials Fact Sheet

I, _____ acknowledge that I have received from Dr. Elona Gaball's office an offer for a copy of the Dental Materials Fact Sheet dated October 2001 and updated in 2004. A copy was made available for my review and to take.

Signature _____ Date _____