LILE BUNAR D.D.S.

WWW.LILEBUNARDDS.COM

PHONE: 949-589-3344

HEALTHY TEETH AND BEAUTIFUL SMILES FOR YOUR ENTIRE FAMILY

22032 EL PASEO #200

RANCHO SANTA MARGARITA, CA 92688

Patient Registration

Title: Mr. Ms. Mrs. Miss Dr. Occupation: _____

First Name: _____ Middle Initial: ___ Last Name: _____

I prefer to be called: _____ Driver License #: _____ State: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Business Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Home Address, Street: _____

City: _____ State: _____ Zip: _____

Employer: _____

General Dentist: _____ Referred By: _____

Physician: _____ Phone: _____

Emergency contact: _____ Relation: _____ Phone: _____

Primary Dental Benefit Plan: _____ Phone: _____

Secondary Dental Benefit Plan: _____ Phone: _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Insured's SS #: _____

Health History

Have there been any changes in your health in the past year? Yes No

Are you under the care of a physician? Yes No

If so, for what are you being treated? _____

Date of last medical examination: _____

Do you have a prosthetic joint? Yes No

If so, describe where: _____ How long ago? _____

Do you have a heart valve replacement or vascular graft? Yes No

If so, describe where: _____ How long ago? _____

Do you have a cardiac pacemaker? How long ago? _____ Yes No

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DID YOU OR DO YOU CURRENTLY HAVE	YES	NO	NOTES	DID YOU OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
Damaged heart valves				Asthma			
Heart Murmur				Have fever/Sinus			
Mitral Valve Prolapse				Eye Disease/Glaucoma			
Rheumatic heart disease				TMJ/Pain and/or clicking of jaws			
High Blood Pressure				Stomach ulcers/GERD			
Heart attack(s)				STD's			
Pacemaker				Drug or alcohol abuse			
Stroke				HIV / AIDS			
Hepatitis A or B				Migraines			
Hepatitis C				Mental health problems			
Kidney trouble, dialysis				Seizures / Epilepsy			
Diabetes				Cancer / Chemotherapy			
Liver Disease				Osteoporosis			
Tuberculosis				Arthritis/Joint disease			
Emphysema				Abnormal bleeding			
Thyroid trouble				Anemia			
Women, are you pregnant?				Do you smoke?			

PLEASE NOTE: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist regarding alternative methods of birth control.

MEDICATIONS

Please list all medicine, drugs, pills, over-the-counter medications: _____

_____

ALLERGIES

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO…	YES	NO	NOTES	ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO…	YES	NO	NOTES
Local anesthetics				Codeine			
Sulfa				Other narcotics			
Penicillin				Aspirin / NSAID's			
Other antibiotics				Latex			

Please list any non-drug allergies: _____

Are there any additional health issues about which the doctor should be told? Yes No

Do you wish to speak to the doctor privately about anything? Yes No

Patient Signature _____ **Date** _____ **Dr. Signature** _____

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Previous Dentist Information

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

City: _____ Zip Code: _____

Reason for changing: _____

Dental History

Oral Health: Excellent Good Fair Poor

Date of last dental visit: _____ Treatment type: _____

Would you like to have a **VELScope oral cancer screening?** Yes No

*Note some insurance do not cover this service: please check your plan details.

Yes No Are you currently having dental discomfort?
If yes, explain _____

Yes No Any injuries to mouth/teeth/head?
If yes, explain _____

Yes No Any missing teeth other than wisdom teeth or orthodontic extractions?
If yes, explain _____

Yes No Have missing teeth been replaced?

Yes No Orthodontic appliances now or in the past?

Yes No Gums bleed when brushing or flossing?

Yes No History of gum disease?

Yes No Any concerns about the appearance of your teeth?

Yes No Does it hurt to bite or chew?

Yes No Do you clench or grind your teeth?
If yes, do you wear a night guard or splint?

Yes No Do you want your mouth properly restored and pain free?

Yes No Doe any type of dental treatment make you nervous?
If yes, please explain bellow: _____

Yes No History of gum disease?

Yes No Concerns about gum disease?

Child / Minor Patients

Yes No Any mouth habits? (Thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc)

Yes No Any unusual speech habits? If yes, explain _____

Yes No Any lost teeth? _____

Yes No Does the patient receive assistance with brushing and flossing?
If yes, how often? _____

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Delta Dental Premier and United HealthCare.**

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier, will be your responsibility.

- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.

- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - 10% Discount for our uninsured cash/check
  - Various financing options with CareCredit®

- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours' notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

- **Short canceled or missed appointments** will be charged one dollar per minute of time allotted for your appointment.

By signing below, I acknowledge I have read and understand the guidelines above.

Signature:_____ Date: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2015

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Dr. LILE BUNAR DDS,
(please check all that apply):

☐ Cell phone: ☐Text Message reminders permitted

☐ Home phone ☐Work ☐ E-Mail:

☐ I am granting permission for Dr. LILE BUNAR DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. LILE BUNAR DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐Work Phone ☐ None- please just ask for a call back

☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other – please list:

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. LILE BUNAR DDS of the dental benefits otherwise payable to me.

I hereby authorize Dr. LILE BUNAR DDS to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: _____ Date: _____