PATIENT INFORMATION

PLEASE TAKE A MOMENT TO UPDATE YOUR INFORMATION TO HELP US INSURE THE QUALITY OF YOUR CARE

Date_____

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____

Work Phone_____ E-mail_____

D.O.B_____ Calif. Driver's License No._____

Preferred Contact Method Home ☐ Work ☐ Cell ☐ E-mail ☐

Emergency Contact Information Name_____

Address_____

Phone #_____ Relationship_____

Primary Insurance Information

Subscriber Name_____

Insurance Co._____

Group#_____ ID#_____

Employer_____

D.O.B_____ Relationship_____

Insured's Social Security #_____

Secondary Insurance Information

Subscriber Name_____

Insurance Co._____

Group#_____ ID#_____

Employer_____

D.O.B_____ Relationship_____

Insured's Social Security #_____

Authorization for Signature on File Release of Information/Financial Responsibility/Authorization for Payment

I, _____ and or _____
Name of Patient (Parent/Guardian) Name of Insured

hereby authorize the office of Juergen Langenbach, DMD, APDC to affix my name to any and all insurance claims or documents as related to any and all health benefits due me and my dependents through my dental insurance company. I hereby authorize payment of dental benefits otherwise payable to me to the office of Juergen Langenbach, DMD. I have reviewed the treatment and fees; I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan. I authorize release of any information relating to the claim. This "Authorization" will be valid from this date or as long as the patient is active in the practice. A photo copy of this document may act as the original.

_____ _____
Signature of Insured Witnessed By

_____ _____
Signature of Patient (Parent or Guardian) Today's Date

PATIENT INFORMATION

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CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patients)_____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patients Signature _____ Date_____ Witness_____

Parent/Responsible Party's Signature_____Relationship to Patient_____

Unencrytped 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/phone message may be misdirected, disclosed to or intercepted by, unauthorized third parties. However you may consent to receive email/phone messages from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

Should you wish to communicate via email or wish to receive phone messages please indicate the email and/or phone number where messages should be left.

Email:_____ Phone Number: _____

Patient Name

MEDICAL HISTORY

Patient Account No. Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No

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, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Patient Name

Patient Account No.

Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Would you like to replace your silver fillings?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No

Please describe _____

Have you ever had an upsetting dental experience?	Yes	No

Please describe _____

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

(Please complete other side)

Juergen Langenbach, D.M.D., A Professional Dental Corporation
15725 Pomerado Road, Ste. 104, Poway, CA 92064
858-451-3110

Financial Guidelines

This is an agreement between Dr. Juergen Langenbach, D.M.D., A Professional Dental Corporation, as creditor, and the Patient/Guarantor named on this form.

Payments: Unless other arrangements are made between this office and the guarantor, payment in full is expected at the time of service.

Payment Options if there is no dental insurance:

- We accept payment by cash, check or credit card.
- In the instance of extensive treatment plans, financial arrangements will be made prior to the commencement of treatment.
- There may be outside financing options available to you. Please let us know if you are interested.

Payment Options if you have dental insurance:

- The deductible, if there is one, and any out-of-pocket portions are requested at the time services are rendered. Payments can be made by cash, check or credit card.
- In the instance of extensive treatment plans, financial arrangements will be made prior to the commencement of treatment.
- There may be outside financing options available to you. Please let us know if you are interested.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show the balance forward from the previous billing period if one applies, any new charges, a finance charge, if applicable, and any payments or credits applied to your account since the last billing period.

Finance Charge: A finance charge will be applied to any portion of your balance that becomes sixty (60) days past due. The **Finance Charge** will be computed at the rate of 1/5% per month or an **Annual Percentage Rate** of eighteen (18) percent. There is a minimum finance charge of $.50.

Returned Checks: There is a $25.00 charge for any checks returned by the bank.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. You are also responsible to know the provisions of your policy. For services that fall in the category of "major" or for extensive treatment plans, we are happy to provide the insurance with a plan of treatment prior to commencing for your benefit. In this way, we can better estimate your out-of-pocket expense.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contractual agreement and its requirements. As with any insurance policy, your insurance company makes the final determination of your eligibility.

Missed Appointments: We ask that whenever you are unable to make your appointment with us that you give a notice of two working days. In this way, we can offer that time to another patient. Our working days are Monday through Thursday. For missed appointments when there is no notice, we reserve the right to charge for this time. Charges, if any, will be determined by the time lost.

I have read and agree to the financial policy of Juergen Langenbach, DMD, A Professional Dental Corporation.

Patient's name: _____

Responsible Party: _____

Signature of Responsible Party: _____Date: _____

Facsimile: 858-451-2916, E-Mail: powaydds@gmail.com

Juergen Langenbach, D.M.D., A Professional Dental Corporation
15725 Pomerado Road, Ste. 104, Poway, CA 92064
858-451-3110

Divorce or other Third Parties: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. If the divorce or separation occurs before treatment has been rendered, the parent authorizing treatment for a child will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will not become involved in third party collections.

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I have read and agree to the financial policy of Juergen Langenbach, DMD, A Professional Dental Corporation.

Patient's name: _____

Responsible Party: _____

Signature of Responsible Party: _____Date: _____

Facsimile: 858-451-2916, E-Mail: powaydds@gmail.com

An Important Word about Your Dental Insurance

In an effort to avoid potential misunderstandings, we are taking this opportunity to explain our relationship and responsibility to you, our patient, regarding your dental benefits. Your benefits are provided by you (in the case of an individual policy) or an employer. We have no control over the quality of policy you or an employer may have chosen. Therefore, our involvement must be limited to a business courtesy to aid you in maximizing your benefits as regulated by policy limitations, whatever they may be. We encourage you to familiarize yourself with your benefits; they are as varied as there are policies.

Currently, the only insurance company we are contracted with is Delta Dental at the Premier level. If you have any other type of insurance, we will be considered out-of-network.

As a courtesy, we will bill your insurance carrier to help you realize as much of your annual maximum as we can but we have no affiliation with nor any control over how they process the claim or determine benefits. You are responsible for your full balance, regardless of your insurance company's actions. It is important to note dual insurance is not a guarantee of 100% coverage.

If there is any follow-up needed (for claims not paid within 60 days) we are happy to make up to two phone calls and/or provide any additional support or information your insurance carrier may need. If our attempts are not successful, we will contact you to let you know that your participation is needed in resolving your claim processing. In the case of disputes, we readily write letters to advocate your ability to maximize your dental benefit but we cannot guarantee they will resolve in your favor.

You may request for predeterminations to see how much the insurance company will pay for services. The important thing to keep in mind is that even having the predetermination in hand is not a guarantee of payment.

We hope this fully explains our role in helping you receive your dental benefits.
If you have any questions or concerns, we encourage you to discuss them with us.

I understand that I am seeing an out-of-network dentist (with the exception of Delta Premier) who will bill my insurance carrier as a courtesy to me. I understand that being out- of- network means my dentist is not bound by a contractual fee limitation. I understand that predeterminations are not a guarantee of payment. I agree to pay my account balance regardless of how dental benefits are determined by my dental carrier.

_____ _____

Patient or Guardian Name Date

Juergen Langenbach, D.M.D., F.A.G.D.
Lynne D. Thomas, D.D.S., F.A.G.D.
15725 Pomerado Road Suite 104
Poway, CA 92064
(858) 451-3110

INSURANCE INFORMATION AND SIGNATURE FORM

Employee/Subscriber Name:
LAST:_____, FIRST:_____ MI____
Employee/Subscriber Social Security Number:_____
Employee/Subscriber Birthdate:_____
Employer Name:_____
Plan or Group Number:_____
Dental Insurance Company: _____
Insurance Mailing Address: _____
_____
Insurance Company Phone #: _____
(If you have a second insurance carrier, please fill out an additional form.)

Signature and Authorization:

I have reviewed my treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____ _____
Signed (Patient or parent, if minor) Date

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

_____ _____
Signed (Insured) Date

Signed:_____Date:_____

INSURANCE INFORMATION

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members