



980 King Drive, #1 King Plaza Center
Daly City, CA 94015

(650) 878-0651 | (650) 878-9575 fax
www.delaramadental.com

Welcome to Our Practice!

We would like to be the first to welcome you to our dental office. Enclosed you will find 5 pages of medical/dental information, as well as several consent forms to sign. Please read each one carefully, fill them out and sign them (including any initials required). These forms can be faxed, emailed as scanned attachments to info@delaramadental.com, or delivered in person during your initial visit to our facility. If there are any questions about anything in the forms, please do not hesitate to call us.

Once again, welcome to our dental practice. We strive to offer a soothing, family oriented dental experience that employs the newest in dental technologies and materials, but still has the ambiance and warmth of a trusted family doctor.

Sincerely,

Dr. Bonita C. Dela Rama, DMD
Dr. Andrew A. Dela Rama, DDS
Dr. Marjorie G. Dela Rama, DMD



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We would like to get to know you better!

Date _____

Name _____

Address _____

Home Phone (_____) _____

Cell Phone (_____) _____

Occupation _____

Work Address _____

Work Phone (_____) _____

Whom May We Thank For Referring You? _____

Emergency Contact/Relationship _____

Phone (_____) _____

Person financially responsible for this account _____

Dental benefit plan carrier _____

Account # _____

SSN _____

Date of Birth _____ Age _____

Medical History¹

Do you have any general health problems? Yes No

If so, please specify: _____

Are you under the care of a physician? Yes No

Name & Address _____

¹ Update: _____
 Sign: _____ Date: _____

To the best of your knowledge, have you ever had any of the following:

AIDS/HIV	Yes	No
Artificial Heart Valves or Joints	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Cortisone Treatments	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Hepatitis	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
Jaw Pain	Yes	No
Kidney and/or Liver Disease	Yes	No
Mitral Valve Prolapse/Heart Murmur	Yes	No
Pacemaker	Yes	No
Prolonged Bleeding	Yes	No
Psychiatric Care	Yes	No
Radiation Treatment or Chemotherapy	Yes	No
Respiratory Disease	Yes	No
Sinus trouble	Yes	No
Stroke	Yes	No
Swollen Neck Glands	Yes	No
Thyroid Problems	Yes	No
Tuberculosis	Yes	No
Tumor Growth on Head or Neck	Yes	No

REMARKS²

² Update: _____
 Sign: _____ Date: _____

Are you currently taking any medications or drugs? Yes No
 If so, what? _____

Are you allergic to:
 Aspirin Local Anesthetic Penicillin
 Sulfa Drugs Iodine Latex
 Other: _____

Dental History

1. Are your teeth sensitive to:
 Heat? Yes No
 Cold? Yes No
 Sweets? Yes No
 Biting Pressure? Yes No
2. Does food constantly get stuck between certain teeth in your mouth? Yes No
3. Are you dissatisfied with the way your teeth look? Yes No
 For example: color, shape, spaces, crowding, etc.
4. Do you have fillings that show in your front teeth? Yes No
5. Do you have any fillings that show when you smile? Yes No
6. If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead? Yes No
7. Have you ever had any teeth removed? Yes No
8. How long have these teeth been missing? _____
9. Do your gums bleed when brushing? Yes No
10. Do you ever avoid any part of the mouth while brushing? Yes No
11. Have you been instructed regarding proper home care? Yes No
12. Do you have an unpleasant taste or odor in your mouth? Yes No
13. Do you smoke? Yes No
14. Do you snack between meals on sweets or chew gum? Yes No

15. How often do you brush your teeth? _____
16. How often do you floss? _____
17. Do you want to learn to control dental disease and retain your teeth? Yes No
18. Has fear of discomfort kept you from regular dental visits? Yes No
19. Are you deeply concerned about the finances required to return your mouth to excellent dental health? Yes No
20. When was your last dental appointment? _____
21. What did you have done? _____
22. How long since your last *thorough* examination with *full mouth x-rays*? _____
23. What prompted you to seek dental care at this time?

REMARKS



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Informed Consent for Use & Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ SSN: _____

Section B: To The Patient – Please Read The Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dela Rama & Garcia Dental Care
Telephone: (650) 878-0651 Fax: (650) 878-9575
1 King Plaza Center
Daly City, CA 94015

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



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Insurance, Financial & Appointment Cancellation Agreement

_____(initials)_____ I certify that I and/or my dependant(s) are covered by insurance with _____(name of insurance company(ies))_____ and assign directly to **Drs. Dela Rama or Garcia** all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signatures on all insurance forms.

_____(initials)_____ The above named doctors may use my and/or my dependant(s) health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services.

_____(initials)_____ I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are financially responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient.

_____(initials)_____ In the event of non-payment by an insurance company or by a 3rd party collections agency; Drs. Dela Rama & Garcia are NOT responsible for handling any disputes between occupational human resource departments, their insurance companies, or their collection agencies.

_____(initials)_____ I understand that filing a claim with my insurance company is a **COURTESY** provided by **Drs. Dela Rama or Garcia**, and not a **REQUIREMENT** of their dental office. Even though Drs. Dela Rama & Garcia do file claims with my insurance, it does not relieve me from my financial responsibility for the payment of all charges.

_____(initials)_____ I understand that every appointment with Dr. Dela Rama or Garcia usually involves many preparatory steps by the doctors and staff, both mentally and physically. In addition, making appointments for long procedures and then failing to show up without excuse deprives another patient of the doctor's time that they desperately need. I agree that a 24-hour advance notice either in person, on the phone, or voice message is required for cancellations of ALL appointments. Any cancellations or failures to appear at my appointment that do not meet the advance cancellation policy will be subject to a \$75 fee per appointment. All treatments will not resume on you, the patient pays their delinquency fees in full.

Signature of Patient or Parent/Guardian (if under 18)

Date



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Informed Consent for Use Of Images & Radiographs

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Section B: To The Patient – Please Read The Following Statements Carefully

Purpose of Consent: Our office normally takes digital intraoral photographs and radiographs (x-rays) for our use in diagnosis, treatment planning, and patient education. Images are saved on our secure office server and associated with your digital chart. However, from time to time, Drs. Dela Rama and/or Garcia use images for educational or marketing purposes.

‘Educational purpose’ is defined as continuing education meetings, discussions with other dentals/specialists regarding treatment, or dental school lectures. ‘Marketing purpose’ is defined as printed images in our office to show “before and after” images of treatment; as well as on the office’s website. Images will be strictly of teeth and/or smiles, and at no time will your identity be revealed if your images are used; all HIPAA rules and regulations apply.

Full Face Images: If a full face image is to be used, and your identity would be revealed either for Educational or Marketing purposes, Drs. Dela Rama or Garcia will provide a separate consent for these purposes.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. You may obtain a copy of this Consent, including any revisions of this Consent, at any time by contacting:

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Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact listed above.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use my images for educational purposes as defined above.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT