Lannie Zarate-Reyes, D.D.S., Inc.
579 Coleman Avenue, Suite 10
San Jose, CA 95110
408-588-1271

Patient Information

Last Name **First Name** **MI**

Nickname **Birth Date** **Social Security Number**

Home Address **Street** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Email**

Work Phone **Employer**

Marital Status (single, married, divorced, separated) **Student (Y/N)** **School Name & Address**

Dental Insurance Information (Primary Subscriber)

Last Name **First Name** **MI**

Social Security Number **Birthdate** **Driver License / ID Number**

Employer **Occupation** **Length of Employment**

Employer Address **Street Name** **City** **State** **Zip Code**

Insurance Carrier **Group ID/Policy Number**

Insurance Claim Mailing Address **Telephone Number**

Please list below if you have any other dental insurance (Secondary Insurance Coverage)

Last Name **First Name** **MI**

Social Security Number **Birthdate** **Driver License / ID Number**

Employer **Occupation** **Length of Employment**

Employer Address **Street Name** **City** **State** **Zip Code**

Insurance Carrier **Group ID/Policy Number**

Insurance Claim Mailing Address **Telephone Number**

Referral Information (Pass by, Website, Employee, Co-worker, Family, Friend) _____

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examination rendered, to my dental insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled. Authorization is hereby granted to Equifax and Lannie S. Zarate-Reyes, D.D.S., Inc. to release information for appropriate credit verification and patient information required.

Signature of Patient/Guardian **Signature of Responsible Party** **Date**

Patient Health History

In case of Emergency (Person's Name/Number):
_____
Date of last Medical Exam: _____How would you describe your health?
_____
Do you have a Medical Physician: _____Name of Physician:
_____

1. Are you now or have you been under the care of a physician within the past five years: _____If so, why:
   _____
2. Have you had any major surgery/hospitalization:
   _____
3. Are you now or have you recently been taking any medication? _____If yes, name of meds and for what
   _____
   _____
   _____
4. Have you taken Phen-fen/Redux before? _____When? _____Have you seen your physician after that?
   _____
5. Have you or are you taking bisphosphonate medication? Yes/No
   When?_____
6. Are you allergic to or have any reactions to any of the following: (mark each applicable box)

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Lidocaine)			Aspirin			Iodine		
Penicillin or any antibiotics			Codeine			Latex Rubber		
Sulfa Drugs			Barbiturates			Others (please list)		
Any metals (e.g., nickel, mercury			Sedatives					

7. **Women Only:**

	Y	N
Are you pregnant or think you may be pregnant?		
Are you nursing?		
Are you practicing birth control medication?		

8. **Do you or have you had any of the following: (please mark each applicable box)**

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement/Implant			Epilepsy			Cold Sores		
Heart Failure			Kidney Trouble			Glaucoma			Genital Herpes		
Heart Surgery			Ulcers			Pain in Jaw Joints			Fainting/Dizzy Spells		
Heart Disease			Arthritis			AIDS/HIV infection			Nervousness		
Angina Pectoris			Emphysema			Liver Disease			Psychiatric Treatment		
Heart Murmur			Tuberculosis			Hepatitis A (infectious)			Sickle Cell Disease		
High Blood Pressure			Asthma			Hepatitis B (serum)			Bleeding Gums		
Rheumatic Fever			Hay Fever/Allergies			Hepatitis C			Tooth Pain		
Congenital Heart Defect			Sinus Trouble			Yellow Jaundice			Bad Breath		
Scarlet Fever			Diabetes			Blood Transfusion			Chronic Headaches		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Neckaches		

Mitral Valve Prolapse			Radiation Therapy			Hemophilia			Cosmetic Surgery		
Heart Pace Maker			Chemotherapy			Syphilis			Cortisone Medicine		
Stroke			Cancer			Leukemia			Others (please list)		
High Cholesterol			Tobacco/nicotine use			Gonorrhea					

Patient Dental History

Name of Previous Dentist and Location _____Date of Last Exam: _____

	Y	N		Y	N
Do your gums bleed while brushing or flossing?			Do you have frequent headaches?		
Are your teeth sensitive to hot or cold liquids/foods?			Do you clench or grind your teeth?		
Are your teeth sensitive to sweet or sour liquids/foods?			Do you bite your lips or cheeks frequently?		
Do you feel pain in any of your teeth?			Have you ever had any difficulty with extractions?		
Do you have any sores or lumps in or near your mouth?			Have you ever had any prolonged bleeding after extractions?		
Have you had any head, neck, or jaw injuries?			Have you had any orthodontic treatment?		
Have you ever experienced any of the following in your jaw?			Do you wear dentures or partials? If yes, date of placement? _____		
a) Clicking			Have you ever received oral hygiene instructions (teeth and gums)?		
b) Pain (joint, ear, side of face)			Do you like your smile?		
c) Difficulty in opening or closing					
d) Difficulty in chewing					

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners.

Signature of Patient/Parent or Guardian: _____Date: _____

Doctor's Signature: _____Date: _____

Doctor's Comments:

_____

Aerosol Transmissible Disease Screening Questionnaire

Patient's Name: _____ Today's Date: _____
Patient's Temperature: _____ Patient's Telephone #: _____

	Y	N
Have you been exposed to anyone with Corona Virus (COVID-19)?		
Do you have a fever (if above 100.4 ◦ F, you must seek medical attention immediately)?		
Have you had a cough for more than 3 weeks that is not explained by non-infectious conditions?		
Have you had coughing fits that interfere with eating, drinking, or breathing?		
In addition to cough, have you experienced:		
Unexplained weight loss (more than 5 pounds)?		
Night sweats?		
Chronic fatigue or malaise?		
Coughing up blood?		
Have you experienced:		
Headache?		
Muscle aches?		
Tiredness?		
Poor appetite followed by painful, swollen salivary glands on one or both sides of the face under jaw?		
Have you experienced shortness of breath?		
Have you had:		
Stiff neck?		
Chills?		
Runny nose?		
Watery eyes associated with the onset of unexplained rash (diffuse rash or blister?		
Mental status change?		
Do you show signs and symptoms of flu like illness during March-October (months outside of US flu season)?		
Do you show signs and symptoms of a flu for longer than 2 weeks at any time during the year?		
(these may include combinations of the following: coughing/other respiratory symptoms, fever, sweating, chills, etc)		
Have you been exposed to anyone with an infectious aerosol transmissible illness (see list below) other than seasonal flu?		

Please check (√) any of the following (ATDs) that you have been diagnosed or exposed to:

√	Aerosol Transmissible Disease (ATDs)	When?	√	Aerosol Transmissible Disease (ATDs)	When?
	COVID-19 – Corona Virus			Smallpox	
	Scarlet Fever			Hemophilus Influenza B (HIB)	
	Avian Flu			Pneumonia	
	Novel Flu			Parvovirus	
	Swine Flu			Pertussis (whooping cough)	
	Chickenpox			Tuberculosis (TB)	
	Shingles			Diphtheria	
	Measles			Meningitis	
	Monkeypox			Mumps	
	Severe Acute Respiratory Syndrome (SARS)			Pharyngitis	
	Strep			Epstein Barr Virus	

List other illnesses you may have been exposed to: _____
_____

DENTIST SIGNATURE:_____ **DATE**_____
Lannie S. Zarate-Reyes, DDS

Lannie S. Zarate-Reyes, D.D.S., Inc.
579 Coleman Avenue, Suite 10
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408.588.1271

NOTICE OF PRIVACY PRACTICES

HOW YOUR HEALTH INFORMATION MAY BE USED TO PROVIDE TREATMENT

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimized scheduling and coordination of care between dental assistants, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training progress for students, interns, associates and business and clinical employees. It is also possible that health information will be disclosed during audits by Insurance Companies, or government appointed agencies as part of their quality assurance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

IN PATIENT REMINDERS

Because we believe regular care is very important to your oral and general health we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy or participating with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders)

ABUSE OR NEGLECT

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment when we believe we are specifically required by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important whom the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT

As permitted or required by State or Federal law we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if you are a victim of crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important in those participating in providing your care.

AUTHORIZATION TO USE OR DISLCLOSE HEALTH INFORMATION

Other than is stated above or where Federal, State or Local law requires us we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patient.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other than family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to read, review and copy your health information including your complete chart, x-ray and billing records. If you would like copy of your health information please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR HEALTH INFORMATION

You have the right to update your records if you believed your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be complete.

DOCUMENTATION OF HEALTH INFORMATION

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to know more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THIS NOTICE

You have the right to obtain a copy of this notice of privacy practices directly from our office at anytime. Stop by or give us a call and we will mail, or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this notice of our private practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms in our notice. If we change our privacy practices we will be sure all of your patients received a copy of the revised notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services. If you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns and complaints in writing.

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PATIENT ACKNOWLEDGEMENT

Patient
Name (s) _____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____
Patient Signature

Date _____

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TRUTH IN LENDING
EXPLANATION OF LATE CHARGES AND FINANCE CHARGES

LATE CHARGE: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater.
FINANCE CHARGE: A FINANCE CHARGE is imposed on those charges not paid in full within 30/60/90/120/150 days of the date you were first billed for the charges. The balance on which any **FINANCE CHARGE** is computed is determined by totaling the charges not paid within the time period shown below on the front of your billing statement.
The **FINANCE CHARGE** is a periodic rate of 1.50 % per month. (An annual percentage rate of 18 %). The **FINANCE CHARGE** is computed by multiplying the balance on which the **FINANCE CHARGE** is computed by the periodic rate shown above. There is a $1.00 minimum **FINANCE CHARGE.**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at 579 Coleman Avenue, Suite 10, San Jose, CA 95110. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 408-588-1271, but doing so will not preserve your rights. In your letter, please include the following information:

- your name and account number
- the dollar amount of the suspected error
- describe the error and explain, if you can, why you believe there is an error.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating,, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow there rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above state conditions.

Signature_____ Date_____

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Lannie S. Zarate-Reyes, D.D.S., Inc.

A photocopy of this document may act as an original.

Signature of Insured_____ Date_____

Lannie S. Zarate-Reyes, DDS, Inc.
579 Coleman Avenue, Suite 10
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OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit that allows you to start treatment today and spread payments over time.

Payment Options

1. **Cash**
2. **Major Credit Cards / FSA / HSA**
3. **CareCredit**

Applying for **CareCredit** only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account for balances after insurance payments: check one

□ **Cash**

□ **Major Credit Card / FSA / HSA**

□ **CareCredit** (Subject to credit approval.) If credit application is declined, another form of payment listed above is required.

_____ _____

Signature of Patient/Responsible Party Date