BEST NATURAL smile™
AESTHETIC & RESTORATIVE DENTISTRY

1260 15TH ST. SUITE 1117 SANTA MONICA CA 90404
310. 393. 0465 TELEPHONE
310. 395. 2288 FAX

BESTNATURALSMILE.COM

OUR GOAL

Our goal is to offer you exceptional service in a relaxed and "state of the art" treatment facility. Providing you dental care with the objective of augmenting and sustaining your overall good health is our number one priority.

The following important guidelines of our treatment facility allow us to focus our efforts and expertise toward our goal by offering you the very best in dentistry. Our highly trained staff is prepared to make your visit a very positive and caring experience. Please, do not hesitate to ask us any questions that you may have pertaining to our services.

Thank you for your confidence in us. We look forward to serving you.

Craig A. Israel, DDS, Diana Broumandi, DDS, Alex D. Lopez, DDS

YOUR FIRST VISIT

Enclosed in this packet you will find our following required forms. Please be sure to sign where indicated. Thank you.

Patient Information * Health Information * Medical History * Dental History * Financial Policy * Credit Card Authorization Form

Medical and Dental History

Your unique history reveals many important key elements to your overall dental health. If you have visited a dentist, within the last two years, please provide us with the contact information where indicated in the follwoing forms, so that we may assist you in transferring your dental records to our office. Please answer each question as you fill out your forms and fill in all check mark boxes so that we may provide you with a comprehensive evaluation. You will have a thorough physical examination of your teeth and oral structures with necessary x-rays. For proper diagnosis we recommend a full series of digital x-rays every 3-5 years based on the doctor's recommendation and check up x-rays on each following yearly interval recare visit. We will also provide a cancer screening of all oral tissue.
A detailed explanation of your needs and a recommended treatment plan will be discussed. Once your initial treatment is completed, we will set your appointment for your next regular dental hygiene visit and checkup at a frequency that suits your needs. Please be sure to ask questions. We are always here to help you in any way possible.

CONCIERGE SERVICE

To ensure efficient and professional care for our patients, we operate on a system of scheduled appointments. We value your time and understand that life can be busy so we provide our patients with a full "Conceierge Service", which includes a prompt response time for all questions, concerns or appointment scheduling. Please call 310-393-0465 or e-mail info@BestNaturalSmile.com and our team will be happy to assist you with scheduling. We do encourage you to set your appointments in advance, so that the time that best suits your needs can be reserved. You can also visit our website at BestNaturalSmile.com and e-mail a request for your appointment in that manner. We will always do our best to respond quickly to you.

At all times we have a listing of patients who are requesting specific time slots. In order to accommodate our entire family of patient's scheduling requests to the best of our ability, we ask that you honor our 24-hour rescheduling policy. There will be a missed appointment fee if an appointment time is not honored, in the case of a no show, or short notice of less than 24 hours.

In careful consideration of each of our patients and your valued busy schedule, every possible effort will be made to maintain your appointment time and seat you within moments of your arrival.

FEES AND PAYMENT

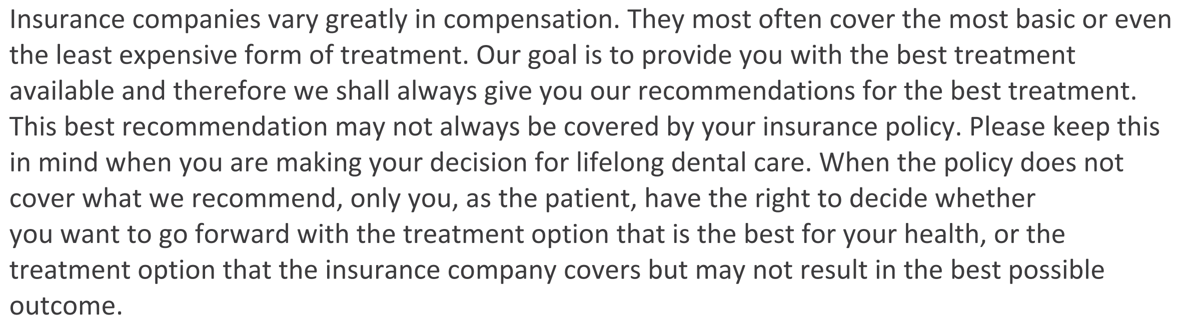
Our fees are based on the current American Dental Association fee guide. Full payment for each phase of your treatment is required at the time of your appointment. For your convenience we accept Cash, Check, MasterCard, Visa, American Express or Discover payments. If extended payments are necessary, upon credit approval, we offer a program with reasonable monthly payments by submitting an application to CareCredit. We partner with this firm, that specializes in easy no interest payments for up to one year. Large cases can be handled in this manner. Our staff is able to answer any questions and assist you.

INSURANCE

If you have insurance benefits, we will gladly submit a claim for services rendered on your behalf, to assist in prompt payment from your insurance company.

We will process your claim electronically. Proof of insurance will be requested at the time of each appointment. If your insurance provider changes please let us know so that we may keep our records up to date and current.

Please note that your insurance policy is an agreement between you, your employer and the company providing the benefits. The insurance company will submit payment to our office for the coverage in your particular plan, and you will be required to pay your estimated portion at the time of each appointment.



Insurance companies vary greatly in compensation. They most often cover the most basic or even the least expensive form of treatment. Our goal is to provide you with the best treatment available and therefore we shall always give you our recommendations for the best treatment. This best recommendation may not always be covered by your insurance policy. Please keep this in mind when you are making your decision for lifelong dental care. When the policy does not cover what we recommend, only you, as the patient, have the right to decide whether you want to go forward with the treatment option that is the best for your health, or the treatment option that the insurance company covers but may not result in the best possible outcome.

In closing, our goal is to eradicate infection and disease. We heavily stress compliance with any necessary treatment needed for the control of disease and infection and for maintenance of your periodontal tissue and dental bone health. Recommended professional Dental Hygiene visits are paramount in our quest for prevention.
We advocate the importance of reconstruction of teeth and dental arches to optimal dental health and function, and we do not support simply “stamping out fires”.

We sincerely hope that you will value our strong dedication and commitment to providing you with a lifelong beautiful smile.

I have read and understand the office policy described above.

___________________________________ ______________________

Patient Signature Date

Best Natural Smile

Contact Email: ____________________

Patient Information

Patient Name: ______________________ Date: __________

Last First MI (Preferred Name)

Gender: __________ Family Status: __________

Social Security #: ______________________ Birth Date: ______________

Phone (Home): __________ (Cell): __________ (Work): __________ Best time to call: __________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐M ☐T ☐W ☐T ☐F

Address: ______________________________

Street Apartment #

____

City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ______________________ Birth Date: ______________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Address: ______________________________

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________

Address: ______________________________

Street City State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

______________________________ Date: __________

Signature of patient, parent or guardian

Health Information – We encourage you to complete this carefully.

- Patient Name: ______________________________ Birth Date: ______________
- Physician Name: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain: ______________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain: ______________________________
- Are you taking any medications, over-the-counter or prescribed? ☐ Yes ☐ No

Name	Dosage	Frequency

- Are you taking any vitamins or herbal supplements? ☐Yes ☐ No

Name	Dosage	Frequency

- Do you use any tobacco products? ☐ Yes ☐ No
- Do you or have you used recreational or illegal drugs? ☐ Yes ☐ No
- Are you allergic or had an unusual reaction to any of the following?

  ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Sulfa ☐ Latex ☐ Metal ☐ Other ______________

- **Women:** Are you: ☐ pregnant/trying to get pregnant? ☐ nursing? ☐ taking oral contraceptives? ☐ post-menopausal

Medical History

Have you ever had any of the following? Please check yes(Y) or no(N):

Y☐ **N**☐ AIDS/HIV positive
Y☐ **N**☐ Alzheimer's disease
Y☐ **N**☐ Anaphylaxis
Y☐ **N**☐ Anemia
Y☐ **N**☐ Angina
Y☐ **N**☐ Arthritis/Gout
Y☐ **N**☐ Artificial Heart Valve
Y☐ **N**☐ Artificial Joints
Y☐ **N**☐ Asthma
Y☐ **N**☐ Blood Disease
Y☐ **N**☐ Blood Transfusion
Y☐ **N**☐ Cancer
Y☐ **N**☐ Chemotherapy
Y☐ **N**☐ Cold Sores
Y☐ **N**☐ Diabetes
Y☐ **N**☐ Dizziness
Y☐ **N**☐ Emphysema
Y☐ **N**☐ Epilepsy
Y☐ **N**☐ Excessive Bleeding
Y☐ **N**☐ Fainting
Y☐ **N**☐ Frequent Cough
Y☐ **N**☐ Genital Herpes
Y☐ **N**☐ Gonorrhea
Y☐ **N**☐ Glaucoma
Y☐ **N**☐ Hay Fever
Y☐ **N**☐ Head Injuries
Y☐ **N**☐ Heart Attack
Y☐ **N**☐ Heart Disease
Y☐ **N**☐ Heart Murmur
Y☐ **N**☐ Heart Pacemaker
Y☐ **N**☐ Hemophilia
Y☐ **N**☐ Hepatitis A
Y☐ **N**☐ Hepatitis B or C
Y☐ **N**☐ Herpes
Y☐ **N**☐ High Blood Pressure
Y☐ **N**☐ Hemodialysis
Y☐ **N**☐ Jaundice
Y☐ **N**☐ Kidney Disease
Y☐ **N**☐ Leukemia
Y☐ **N**☐ Liver Disease
Y☐ **N**☐ Low Blood Pressure
Y☐ **N**☐ Mental Disorders
Y☐ **N**☐ Mitral Valve Prolapse
Y☐ **N**☐ Nervous Disorders
Y☐ **N**☐ Pain in Jaw Joints
Y☐ **N**☐ Pregnancy
Due Date: __________
Y☐ **N**☐ Radiation Treatment
Y☐ **N**☐ Respiratory Problems
Y☐ **N**☐ Rheumatic Fever
Y☐ **N**☐ Rheumatism
Y☐ **N**☐ Scarlet Fever
Y☐ **N**☐ Shingles
Y☐ **N**☐ Sinus Problems
Y☐ **N**☐ Stomach Problems
Y☐ **N**☐ Stroke
Y☐ **N**☐ Syphilis
Y☐ **N**☐ Thyroid Disorder
Y☐ **N**☐ Tonsillitis
Y☐ **N**☐ Tuberculosis
Y☐ **N**☐ Tumors
Y☐ **N**☐ Ulcers
Y☐ **N**☐ Venereal Disease

OTHER:
____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ______________
Signature of patient, parent or guardian

Dental History

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: ____
- Have you been told you have gum disease or periodontal disease? ☐ Yes ☐ No
- Have you had periodontal surgery? ☐ Yes ☐ No Dentist Name: ______________________Date:_________
- Are you interested in information about quitting the use of tobacco products? ☐ Yes ☐ No
- Are you satisfied with your smile? ☐ Yes ☐ No

Comments: ____
- Are you interested in whitening your teeth? ☐ Yes ☐ No

Comments: ____
- Have you ever considered cosmetic dentistry? ☐ Yes ☐ No

Comments: ____
- Have you been diagnosed with TMJ? ☐ Yes ☐ No
- Do you have frequent pain or muscle tension in your jaw, head or neck? ☐ Yes ☐ No
- Do you have popping or clicking in your jaw? ☐ Yes ☐ No
- Are you aware of any clenching or grinding of your teeth? ☐ Yes ☐ No
- Have you ever worn a bite splint? ☐ Yes ☐ No

Previous Dental Information

We make every effort to obtain your previous dental records and dental x rays that are current, prior to your first visit.

Previous Dentist Name ____

Phone Number ______________ City ___________________ State _____ Date of Last Visit ____________

Date of Last Professional Cleaning ______________________ Date of Last X-rays ______________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Advertisement ☐ Google ☐ Yahoo ☐ Yelp ☐ Facebook ☐ Gift Card ☐ Our Blog ☐ Other _______________

Name of person or office referring you to our practice: ____

____ **Date:** ________________________

Signature of patient, parent or guardian

UPDATE SIGNATURES

______________________________________ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

______________________________________ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

______________________________________ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

______________________________________ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

______________________________________ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent or guardian

Financial Policy

If You Have Dental Insurance

As a courtesy to our patients, our office will file cliams to the patient's insurance carrier when insurance information is provided. Our office recommends that each patient become familiar with their insurance coverage including deductibles, co-pays, and yearly maximums as each insurance company determines their own level of reimbursment. For major services we can submit a treatment pre authorization when requested.

Please remember, payment for professional services is the responsibility of the patient. Services are provided without the assumption they will be paid for by an insurance company. Any balance after payment by insurance is posted is due and will be billed to your credit card on file. Major services require patient payment in full at the time of service. We require a $30 advance payment for all initial visits and emergency patients with or without insurance coverage.This advance payment will be applied to your treatment cost. This deposit will be applied to any missed confirmed appointment time without 24hrs advance notice. Interest will be charged on all accounts at the rate of 1.5% ($1.00 minimum). A $35 service fee will be charged on all checks.

I hereby authorize Best Natural Smile to furnish the insured's insurance carrier(s) information that said insurance carrier may request concerning claims. I hereby assign to Best Natural Smile all money to which we are entitled for expenses related to the services performed from time to time, but not to exceed my indebtedness to Best Natural Smile. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my treatment is completed. I understand that I am financially responsible to Best Natural Smile for charges not covered by this agreement.

____ Date: ____________ Relationship to Patient: ______________________________
Signature of patient, parent or guardian

If You Do Not Have Dental Insurance

Payment in full is due at the time of service. Surgical treatment plans require payment in full at booking. A $30 advance payment is required for all initial visits and emergency patients. This advance payment will be applied to your treatment cost or to any missed confimred appointment time without 24 hrs advance notice. This office does not extend personal lines of credit. Interest will be charged on all accounts at the rate of 1.5% ($1.00 minimum). A $35.00 service fee will be charged on all returned checks.

Please indicate your preferred method of payment.

- ☐ Cash, personal check or money order (10% discount for services over $100)
- ☐ Visa / MasterCard / Discover / Debit Card
- ☐ CareCredit (no interest/short term and low interest/extended term plans available)

Cancellation Policy

For any change in your scheduled visit with less than 24 hours advance notice given Monday through Friday, the following charge will apply. This fee will be charged to your credit card on file.

Dental Hygiene Visit $60 per hour

Doctor Visit $150 per hour

I understand that I am personally responsible for all charges incurred at the office of Best Natural Smile

____ Date: ____________ Relationship to Patient: ______________________________
Signature of patient, parent or guardian

Best Natural Smile Credit Card Authorization

A credit card on file is required for all first time patients and those patients in treatment with insurance.

Please complete the following information.

ACCEPTED CREDIT CARDS (Check One)

☐ **VISA** ☐ **MASTER CARD** ☐ **DISCOVER** ☐ **AMEX**

Credit Card Number: ______________________________

Expiration Date: ____________ **3 Digit Security Code:** ________

Name on Card: ______________________________

Credit Card Billing Address: ______________________________

____

____

Phone Number: ______________________________

Authorized Signature: ______________________________

____ **I authorize Best Natural Smile to charge my credit card on file for any balance due on my account.**

(Please Initial)

a gorgeous healthy smile is worth a thousand words...

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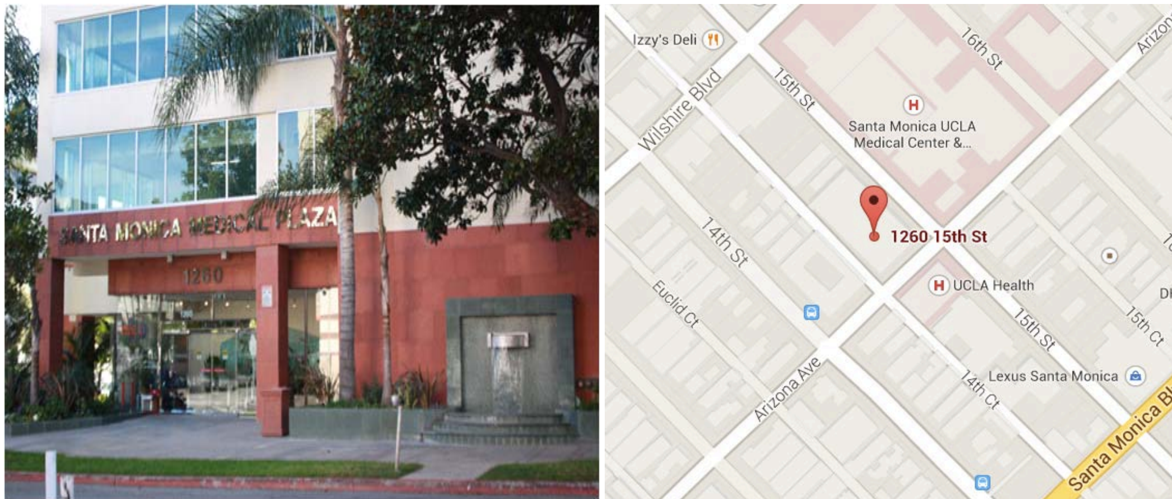

Our office is located in the Santa Monica Medical Plaza

1260 15th Street, Suite 1117 (eleventh floor) Santa Monica CA 90404

Metered parking is available on all surrounding streets. There is also a metered parking lot on 14th Street and Wilshire Blvd directly behind Unleashed Pet Store. You may choose to park in the building's attached parking garage however validation is not provided.

Please allow yourself an extra 15 minutes prior to your first visit.

We look forward to meeting you!

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*For your information **only** is a copy of our Notice of Privacy Practices that federal law requires all health care providers to give to the patient. Thank you for allowing us to serve you.*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (4/13/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes.
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Decedents: We may disclose health information about a decedent as authorized or required by law.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

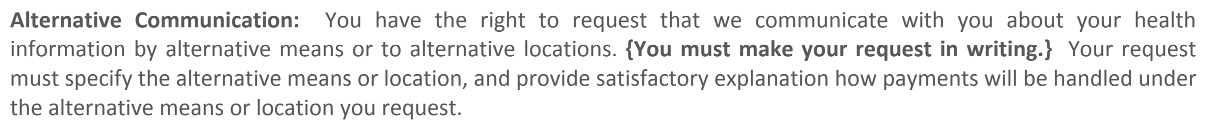
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).



Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Christine Fontanilla
Telephone: 310.393. 0465 Fax: 310.395.2288
E-mail: tinfonta@aol.com