August De Oliveria DDS

Welcome!

Welcome to our dental office. We are very excited to have you here as our patient. Our staff would like you to know that we are committed to providing you with the best care possible. Successful relationships are built on trust and communication. It is our goal to earn your trust and take care of your dental needs. If you ever have any questions regarding treatment, office policies, or anything else, please do not hesitate to ask any staff member or doctor.

In order to help us achieve these goals, we ask that you review the following office policies, and fill out and sign the following forms (patient information, health history and HIPPA). If you have any questions regarding these forms, please ask us.

INSURANCE: Our office is a Delta Dental PPO, Aetna Extend, United Concordia Elite Plus and Guardian PPO provider. We do not have a contractual arrangement with any other insurance company. However, we do want to help you receive the maximum reimbursement to which you are entitled too. As a convenience to you, we will help you process your insurance claims so that you can receive the maximum benefit.

FINANCIAL POLICY: We accept Visa, MasterCard, American Express and Care Credit. We deliver the finest care at the most reasonable cost to our patients. Therefore, payment is due at the time the service is rendered, unless other arrangements have been made in advance. As a courtesy, we will collect your estimated insurance potion from you carrier, but will ask you for your portion at the time of service. If you have any questions, please ask the front desk. *Please remember you are fully responsible for all fees charged by this office, regardless of your insurance coverage.*

CANCELLATION POLICY: We require at least **24 hours notice of cancellations** of scheduled appointments. Late notice or missed appointments may result in charges since that time was specifically allotted for you. In addition, late patients may need to be rescheduled as we try to be on time for every patient scheduled. We do understand that on occasion, emergencies and illnesses are unavoidable. Please call us so that we can reschedule your appointment.

RADIOGRAPHS (X-RAYS): I choose carefully which and when x-rays are taken. X-Rays allow me to see everything I cannot see with my own eyes. Without them, I would not be able to provide dental treatment at the high level I am accustomed too. Our office utilizes digital x-rays, which reduce your exposure significantly compared to traditional x-rays. If you have any concerns, please speak with me.

I, THE UNDERSIGNED, HAVE READ AND AGREE WITH THE TERMS AND CONDITIONS LISTED ABOVE:

_____ _____

Patient Signature Date

5400 Balboa Blvd. #231
Encino, CA 91316
P: 818-783-2981 F: 818-784-5882

Patient Information

Patient's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Birth Date: _____ Age: _____ SS#:_____

Please Circle One: Single Married Widowed Separated Divorced

Cell Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____

Driver License: _____ Pharmacy: _____

Date of last Exam and Cleaning: _____

Please tell us how you heard about us: _____
Whom may we thank for referring you to our practice?

Primary Insurance Information

Policy Holder's Name: _____ Birth Date: _____

Relationship to Patient: _____ SSN#: _____

Name of Employer: _____ Group #: _____

Insurance Co.:_____

Member/ Subscriber ID#: _____

Patient Consent

The undersigned herby authorizes the Doctor to take x-rays or use any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to take photographs, slides, and videos of my teeth, jaws, and face that may be used in Dental Education, for myself and others, including but not limited to training purposes, lectures, presentations, etc. They may also be used for marketing material and advertisements, including limited use on social media, websites, printed materials, and in-office demonstrations. I understand that my dental insurance is contract between the insurance carrier and the doctor. Therefore, I am responsible for all dental fees. Fees are due and payable at the time of service unless prior arrangements have been made. I understand that the information I have given is correct to the best of my knowledge; that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in medical status.

Patient's Signature (or Parent of child): _____ Date: _____

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