WELCOME

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

cellphone #

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

Dr. Susan T Lee DDS Inc
HIPAA Information and Consent Form

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Spa Dentistry

2726 Aborn Road | SAN JOSE CA, 95121 | (408) 270-7723 spadentistry@yahoo.com

Written Financial Policy

Thank you for choosing Susan Lee DDS, Inc.. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Discover Card, Check or Visa, Mastercard

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $500 or more.

- Convenient Monthly Payment Plans[1] from CareCredit and Chase Financial
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Spa Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $25 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice for a weekday appointment. However, there is a **48** hour cancellation policy in place for Saturday appointments.

A non-refundable fee of $50 will be charged to your account for any cancellation not within 48 hours on Saturday appointments.

Spa Dentistry charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

DENTAL TREATMENT CONSENT FORM

Indicated on my examination, I, _____ consent to the following dental treatment. I agree to the use of local anesthesia upon the recommendation of Dr. Lee. I am aware and have been advised of the probable complications of the diagnosed procedures, anesthesia and drugs. I understand that occasionally there are complications following dental treatment, or the administration anesthesia or the prescription of drugs which can result in a wide variety of complications specific to those procedures or medications being used or performed and cross reactions with other medications or physical conditions already present. I believe the health history which I have reviewed and signed to be accurate and complete and all information provided which may be of importance to my oral and physical health.

___EXTRACTIONS / ORAL SURGERY

The most common complications to extraction or oral surgery are pain, swelling, nausea, vomiting, bruising, bleeding, tingling or numbness of the lip, gum, face or tongue due to nerve damage, post infection, sinus complication or damage to other teeth, bone, T.M.J., or neck and unfavorable reactions to drugs or anesthesia.

___COMPOSITE (WHITE) OR AMALGAM (SILVER) FILLINGS

The most common complications to fillings are pain, sensitivity to temperature changes or foods, fracture tooth structure, nerve damage, damage to other teeth, occlusal (bite) discrepancies, T.M.J complications, or reaction to drugs or anesthesia.

___CROWNS AND BRIDGES

The most common complications are pain, sensitivity to temperature changes or foods, tooth nerve damage, fracture of tooth structure, damage to other teeth, occlusal (bite) discrepancies, T.M,J. complications, periodontal complications, tooth loss, esthetic limitations, reactions to drugs or anesthesia.

___ROOT CANAL THERAPY

The most common complications are pain, swelling, infection, tooth fracture, numbness of lips, face tongue, damage to crowns, bridges or teeth, tooth loss, diagnostic inconsistency, reactions to drugs or anesthesia.
I understand teeth treated with root canal therapy even under the best circumstances can fail. Root canal teeth must be normally restored with crowns and posts or bridges.

___PERIODONTAL CLEANING / SCALING

The most common complications are pain, bleeding, tissue (gum) laceration, sensitivity to temperature foods, swelling, ulceration (infections), tooth fracture, crown fracture, breakage of fillings. Reactions to fluoride treatment can be allergic reaction, nausea, or vomiting.

___REMOVABLE DENTURE / PARTIALS

The most common complications to fabrication or relining of removable appliances are pain, ulceration (mouth sores), welling, temporary pronunciation adaptations, inadequate fit or appearance, occlusal (bite) discrepancies, TMJ syndrome, dry and cracked lips, or gagging. Also may require several adjustment appointments after delivery.

RISKS, BENEFITS, AND ALTERNATIVES

_____*CROWNS / BRIDGES*

BENEFITS: Improve appearance and prevent tooth fracture; Replace missing teeth permanently (cemented); Can improve chewing and speech efficiency; Repair broken down tooth; Eliminate food trap; Repair tooth that no longer can be filled; To provide solid structure for partial denture; attachment

POSSIBLE COMPLICATIONS: Porcelain portion of crown may fracture Crown; may come off and require recementation; Tooth may abscess and require further treatment (may not show up until later); Future decay may require a new crown

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Tooth may fracture and need extraction; Tooth may need a root canal in addition to the crown; Teeth will drift and lean over; May lose back teeth due to shifting; Periodontal problems (Gum disease) Can reduce chewing efficiency

ALTERNATIVES: Implants, Removable Partials, or no teeth in the spaces (no treatment).

_____*PERIODONTAL CLEANING*

BENEFITS: Look nicer; Cleaner mouth; Eliminate odors, tartar, and infection; Prevent further gum disease; Reduce overgrown tissue and food pockets

POSSIBLE COMPLICATIONS: Sensitive teeth and/or gums; Feeling of spaces between teeth; Fillings may be loosened (normal if filling was ready to fall out); May need to be repeated in future.

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Stains on teeth and Odors; Progressing gum disease; May lose teeth sooner

ALTERNATIVES: More frequent appointment for scaling or no treatment.

_____*EXTRACTIONS*

BENEFITS: Last resort for non-restorable tooth; Eliminate pain and infection; Remove teeth that are out of position

POSSIBLE COMPLICATIONS: Fractured tooth particles may remain; Irritation to nerves may cause temporary or permanent numbness, Part or all of tooth may be lodged in sinus, requiring more surgery; serious infection may require extended healing period; Jaw may be stiff and difficult to open for a time after treatment; Fragile or thin jawbone may fracture

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Spread of infection, swelling, or pain

_____*FILLNGS*

BENEFITS: Eliminate decay; Relieve pain; Fill in hole and cover eroded area

POSSIBLE COMPLICATIONS: Tooth may abscess from the filling; May fracture the tooth; Tooth may be sensitive to temperature changes; Filling may fall out

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Tooth may fracture and may need extraction; Decay can get larger and pain can occur; May result in the need for a root canal

ALTERNATIVES: Extraction or no treatment.

_____*X-RAYS*

BENEFITS: More complete diagnosis; Can find hidden problems; Can make a determination of treatment; Taken by licensed personnel

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Cannot perform dental procedure, incomplete dental diagnosis and examination.

_____*LOCAL ANESTHETICS*

BENEFITS: Avoid pain during treatments and procedures

POSSIBLE COMPLICATIONS: Gum sores and bruising; prolonged numbness may extend beyond; normal and can lead to nerve damage; in rare instances, possible consequences may; include all those applicable to General Anesthesia, including allergic reactions up to and including death

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Mild to severe pain during and after treatment

ALTERNATIVES: Willingness to accept pain during treatment

_____*DENTURES/PARTIALS*

BENEFITS: Cost

POSSIBLE COMPLICATIONS: Can rock or stress teeth may loosen own natural teeth; Metal clasps are sometimes visible; Decay can occur under clasps. Usually some amount of movement from the partials (rocky and unstable).

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Same as under crown / bridgework

ALTERNATIVES: Bridgework, implant or no treatment.

_____*ROOT CANAL*

BENEFITS: Eliminates infection and relieves pain; Save the tooth

POSSIBLE COMPLICATIONS: Perforation of root or broken files complicating completion; Undiagnosable root fracture or auxiliary canal means failure and extraction

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING: Extraction of tooth.

Date: _____

Patient Name: _____

Patient or Parent Signature: _____

Spa Dentistry
Dr. Susan T. Lee
2726 Aborn Road
San Jose, Ca 95121
(408) 270-SpaD

Photography Release and Consent

I, _____ (Participant) irrevocably grant to Spa Dentistry, (Licensor) its subsidiaries, affiliates, nominees, licenses, their successors, and assigns, those acting with its authority, with respect to the photographs, film or tape taken of me by or on behalf of the Licensor (the "Pictures"), the unrestricted, absolute, perpetual, worldwide right to:

a) reproduce, copy and modify, edit, create derivatives in whole or in part, or otherwise use the pictures or any part thereof in combination with or as a composite of other matter, including, but not limited to, text, data, images, photographs, illustrations, animation and graphics, video or audio segments of any nature, in any media or embodiment, now known, hereafter to become known, including, but not limited to, all formats of computer readable electronic magnetic, digital laser or optical based media (the "Works") for any purpose whatsoever, including without limitation to electronic and web content, and

b) use and permit to be used my name, whether in original or modified form, in connection with the Works as Licensor may choose,

c) and display, perform, exhibit, distribute, license, self, transmit or broadcast the Works by any means now known or hereafter or become known.

I hereby waive all rights and release and discharge the Licensor from, and shall neither sue nor bring any proceeding against any such parties for any claim, demand or cause of action whether now known or unknown, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the Pictures.

I agree that there shall be no obligation to utilize the authorization granted by me hereunder. The terms of this authorization shall commence on the date hereof and be without limitation. I warrant and represent that I am "over" the age of 18 years and that I am free to enter into this agreement.

_____ _____
Participant Signature Date

_____ _____
Licensor Date