Smile Gallery Dental

David M. Datu, D.D.S., Inc.
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www.smilegallerydental.com

Welcome to Smile Gallery Dental!

We are delighted you have considered our practice in your search for excellent dental care.

At Smile Gallery Dental we are committed to provide you with complete thorough evaluations, which are simple and well communicated by both Dr. Datu and his staff. This is done in a friendly and comfortable environment with professional attitude from the initial evaluation and in numerous follow up communications. Our number one priority is our patient's utmost satisfaction. We will provide you with professional excellence in all phases of your dental needs, from handling insurance claims to providing you with financial options you are comfortable with. This helps our patients to be able to experience the confidence a more beautiful smile brings.

Dr. Datu graduated in 1992 from the University of Southern California School of Dentistry. He continues on as part time dental faculty for USC, which he was awarded for excellence in teaching. He is also a member of the USC mobile clinic. Dr. Datu has attended several education courses in Periodontal Surgical Skills, Advanced Removable Prosthetics and Cosmetic Dentistry and is certified in Branemark Implantology and Prosthodontics. His focus is in Cosmetic and Family dentistry with the most sophisticated and advanced smile enhancing. Techniques from relatively simple options to improve your smile, to procedures that can reverse the signs of dental aging. Find out what modern dentistry has to offer you.

Call our office for a complimentary exam and consultation appointment at (714) 998-2241.

We look forward to treating your dental needs.

Yours In Dental Health,

Smile Gallery Dental
Dr. David Datu & Staff

Welcome!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Widowed

Hm #: (____)_____ Cell / Other #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Person Responsible for Account: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: ____/____/____ DL #: _____

Relative or Friend not living with you.

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

CONTINUED ON BACK

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	Yes / No Blood in stools	Yes / No Frequent vomiting
Yes / No Fainting spells	Yes / No Diarrhea or constipation	Yes / No Jaundice
Yes / No Recent significant weight loss	Yes / No Frequent urination	Yes / No Dry mouth
Yes / No Fever	Yes / No Difficulty urinating	Yes / No Excessive thirst
Yes / No Night sweats	Yes / No Ringing in ears	Yes / No Difficulty swallowing
Yes / No Persistent cough	Yes / No Headaches	Yes / No Swollen ankles
Yes / No Coughing up blood	Yes / No Dizziness	Yes / No Joint pain or stiffness
Yes / No Bleeding problems	Yes / No Blurred vision	Yes / No Shortness of breath
Yes / No Blood in urine	Yes / No Bruise easily	Yes / No Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening of arteries	Yes / No Emphysema or other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship**: _____ **Phone Number**: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

David M. Datu, D.D.S, Inc.
1107 E. Lincoln Ave. Suite #201
Orange, Ca. 92865

PAYMENT POLICY

Our goal is to deliver the fines and most cost effective health care treatment available today. *Following diagnosis the doctor will advice you of your plan for treatment. Additionally, we will discuss with you the cost of today' s and future treatments.*

APPOINTMENTS:

Your appointment is pre-arranged. Your appointment time is reserved exclusively for you. Failure to keep your scheduled appointment or cancel your appointment with less than 24 hours notice if you need to cancel for a Monday appointment you must call no later than Friday after 5pm for the surcharge not to apply of $45.00. When you cancel appointments with reasonable notice we can better accommodate other patients.

PAYMENT:

Our office policy is that payment is due at the time services are rendered. By not having to bill we can keep our costs down and pass that savings on to our patients. We are sensitive to the fact that some people may not be able to pay cash for their treatment therefore; we offer several alternative payment programs for you convenience.

1.) CASH OR CHECK
2.) MASTER CARD, VISA & DEBIT
3.) CARE CREDI & LENDING CLUB SOLUTION

PLEASE INDICATE BELOW THE FORM OF PAYMENT YOU WISH TO USE TO SETTLE YOUR ACCOUNT TODAY OR FUTURE TREATMENT:

- ☐ CASH
- ☐ CHECK
- ☐ CREDIT CARD (VISA, MASTERCARD)
- ☐ DEBIT
- ☐ CARE CREDIT
- ☐ LENDING CLUB SOLUTIONS
- ☐ OTHER

PLEASE NOTE:
THERE WILL BE A FEE OF $25.00 FOR EACH BANK RETURNED CHECK ALONG WITH A 1.5% INTEREST CHARGED MONTHLY TO YOUR STATEMENT OF TOTAL CHARGES REFLECTING PAYMENT.

INSURANCE:

As a courtesy, we will be happy to bill your insurance for you. If you are a member of a dental insurance company for which we are a participating provider your co-payment and/or deductible is due at the time of service. If for any reason your insurance company does not pay for a procedure you will be responsible for the remaining balance. If you have any questions regarding your benefits please contact your dental insurance for a benefit booklet.

Signature of responsible party: _____ Date: _____

David M. Datu, D.D.S, Inc.
1107 E. Lincoln Ave. Suite #201
Orange, Ca. 92865

Welcome To Our Office

Our doctor and staff would like to welcome you and your family to our office and encourage you to ask any questions regarding our office policies and services.

We strive for excellence in every aspect of your dental care and always do our best. We respect your appointment time, and make every effort to stay on schedule ourselves. Since we are rarely late, please understand if we are delayed because of an unexpected dental emergency. If you have an emergency dental problem you will be seen the same day you call. Please keep in mind that you will be worked into the schedule due to our pre-scheduled appointments too there will be a wait.

For your information our dental team is comprised of an Office Administrator, Financial Coordinator and Registered Dental Assistant alongside the Doctor. We provide all aspects of dental services from PREVENTAIVE CARE, RESTORATIVE (fillings, crowns, implants, etc.), EXODOTIA (extractions), COSMETIC DENTISTRY (whitening systems, porcelain crowns, composite fillings esthetics, etc.), as well as, REMOVABLE PROSTHESIS (full and partial dentures).

Our patient' s age group is diversified. We treat children as well as adults. Our patient' s needs vary according to the problems they present, and on occasion we will refer to outside specialists, whom we personally know to be caring practitioners.

PATIENT PRIVACY:
Our office makes every effort to maintain patient privacy. Our staff is trained using HIPPA guidelines on the most effective way of maintaining our patients most private and personal information. If you have any questions or have not received your copy of the "Notice of Privacy Practices" please speak to Nicole our Privacy Officer.

OUR OFFICE HOURS:

Monday, Wednesday & Friday	9:00 am _ 5:30 pm
One Saturday a Month	9:00 am - 5:30 pm

We try very hard to meet all of the needs of our patients and to accommodate them. If you have any special needs, please ask us and we will do our best to work with you. In case of an emergency after hours our Doctor could be reached @ (714) 720-9090

MEDICATIONS:
Prescriptions and refills will be considered during office hours only. This helps us keep accurate records of medicine consumption to be maintained in the patient chart for review by State Pharmacy Review Board. This also allows us time to verify the accuracy of your prescription. Due to State Pharmacy Regulations, refills will not be provided to any patients who have not been seen in the office for more than six months. Again, we welcome you to our office. Please feel free to ask any questions that you may have.

I have read and understood the above information.

Signature_____ Date _____

Guardian _____ Date _____

Photographic Release

Your signature below indicates your consent for Smile Gallery Dental/David M. Datu D.D.S., Inc. to use, reproduce, and publish photographic or computer illustrations of your face, mouth and teeth for educational or marketing purposes, and you waive claim against any party based on the usage of the images, or make any claim that the use of the images defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy. It is not mandatory that you initial this paragraph, and you agree that if you choose to initial this paragraph, it is done so freely and voluntarily.

Patients Signature: _____ ***Date:*** _____
Dr.'s Signature: _____ ***Date:*** _____
Witness Signature: _____ ***Date:*** _____

SMILE GALLERY DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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, and of other important matters about 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:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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 Person 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 heath 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.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

SMILE GALLERY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____